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ABSTRACT

The first of a series of hearings on child health issues was held in an effort to obtain a better understanding of the causes of the United States' low rank among industrial nations on indices of child health and prosperity and of models other nations use to improve children's health care, access to delivery systems, and cost containment. Contents of the report provide: (1) an introductory discussion and fact sheet on child health in developed nations; (2) a minority fact sheet on the same topic; (3) a general discussion of what can be learned from other industrial nations; (4) a description of a home visiting program in England that provides families with support and guidance regardless of family income; (5) a discussion of Canada's universal health insurance system; (6) a description of the work of maternal and child health teams that perform routine physical examinations for all children who attend the universally available preschool in France; (7) an overview of operational aspects of preventive pediatric services provided in health stations in every Norwegian community; (8) a description of the preventive health care system in the Netherlands; and (9) a report of research findings on the preventive health services for children in 10 Western European nations. A panel discussion and a statement on the main cause of and remedies for the United States' child health problem conclude the report. (RH)

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CHILD HEALTH: LESSONS FROM DEVELOPED NATIONS

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HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 20, 1990

Printed for the use of the
Select Committee on Children, Youth, and Families

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CHILD HEALTH: LESSONS FROM DEVELOPED NATIONS

TUESDAY, MARCH 20, 1990

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN,
YOUTH, AND FAMILIES,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room 2322, Rayburn House Office Building, Hon. George Miller (chairman) presiding.

Members present: Representatives Miller, Boggs, Martinez, Evans, Bliley, Holloway, and Senator Chiles [retired].

Staff present: Karabelle Pizzigati, staff director; Jill B. Kagan, deputy staff director; Madlyn Morreale, research assistant; Dennis G. Smith, Minority staff director, Carol Statuto, minority deputy staff director; and Joan Godley, committee clerk.

Chairman MILLER. The select committee will come to order. The purpose of today's hearing is to listen to witnesses on the issue of Child Health: Lessons from Developed Nations.

The United States for decades has been a dominant economic power and must now contend with its international competitors in more ways than one. Just yesterday, the Select Committee on Children, Youth, and Families released a report on international comparisons of child well-being prepared by the U.S. Bureau of the Census, that shows the U.S. trailing other industrial nations in the health and prosperity of its children.

The purpose of today's hearing is to get a better understanding of why that might be and what models are being used in other nations to improve the health care of their children, the access to health care delivery systems and, hopefully, the cost containment of some of those systems.

The report that the select committee released yesterday raised many, many questions about comparable rates and the method of comparison between various nations and the United States, but it didn't answer all of those questions.

Today is the first in a series of hearings that the committee plans to hold that will hopefully help us answer some of those questions as we look at major health care initiatives in this Congress by our colleagues on the Committee on Energy and Commerce and the Committee on Ways and Means. These committees are looking for improved ways of incorporating children into the health care system of this country, especially low-income children that by all means of measurement seem to be disproportion-

ately left out of the health care delivery system in the United States.

[Opening statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

The United States, for decades a dominant economic power, must now contend with its international competitors in more ways than one. Just yesterday, the Select Committee on Children, Youth, and Families, released a report on international comparisons of child well-being prepared by the U.S. Bureau of the Census, that shows the U.S. trailing other industrial nations in the health and prosperity of its children.

Demonstrating higher U.S. rates of infant mortality, teenage pregnancy, youth homicide and child poverty than in most other industrialized nations, the study raises serious questions about U.S. policy priorities, the future of our children and youth, and our prospects for competing in world markets.

Experts have repeatedly warned that the United States is losing more than 20% of its children to poverty, ill health, malnutrition, disability and school failure. When children start out with social and educational deficits, the capabilities of our future labor force are severely thwarted. America cannot be productive, cannot compete, and will not succeed, if we abandon our human resources to certain failure.

The time has come to thoughtfully consider the practices of other comparable countries, which in many important areas, are achieving better health and economic outcomes for their children and families, despite their smaller gross national product.

That is why I am especially pleased that the Committee has the opportunity today to explore the successful maternal and child health policies that frequently result in healthier children in four European countries and our closest neighbor, Canada.

When it comes to health care, the U.S. stands alone. We spend a higher percentage of our GNP on health care than any other industrialized country; yet, on the most important indicators of child health, we lag way behind.

One of the more egregious disparities between the U.S. and other nations is infant mortality, which has always been a benchmark of a society's commitment to children. The U.S. infant mortality rate ranks behind 21 other industrialized nations, and 300,000 infants die or are born too small each year.

But as critical as it is, infant mortality is not the only indicator of child health.

Some 11 million children in the U.S. have no health insurance and at least seven million children don't even receive routine medical care.

Forty percent of U.S. preschool children are not immunized. In some inner-city areas and isolated rural communities the percentage is as high as 55%. We're even beginning to see resurgences of childhood diseases, such as measles and whooping cough, that we had long since thought were eradicated.

Childhood poverty, the greatest predictor of poor child health outcomes, is worse in the U.S. than in most other industrialized countries, and financial barriers are by far the most common and significant reasons that women and children don't receive the health care they need.

By contrast, in Europe or Canada, no pregnant woman has to ask how, or where, she will receive prenatal care, or who will pay for it. No child is denied preventive health care, including immunizations, because of an inability to pay.

And, compared with our allies in Europe, we fall far short of offering families in need support services such as respite care or home visiting.

Not every country is completely comparable to the U.S., and their disparate policies may not be appropriate here. But, through greater comparative study, we can translate some of their successes to our own cultural, economic and political setting.

Today we will hear about the implications for children of Canada's universal health insurance system; about a home-visiting program in England that provides families with on-going support and guidance regardless of family income; and maternal and child health teams that perform routine physical exams for all children who attend universally-available preschool in France. New information derived from a study in progress dealing with preventive health services for children in ten Western European nations will also be presented.

I want to welcome our international guests and thank them for coming such a long way to share their expertise and their successes. And I want to thank the American Academy of Pediatrics for their vision and commitment on behalf of children and for bringing these experts together to make this hearing possible.

I look forward to your testimony.

CHILD HEALTH: LESSONS FROM DEVELOPED NATIONS

A FACT SHEET

MILLIONS OF U.S. CHILDREN LACK HEALTH INSURANCE AND ARE LESS HEALTHY

- Unlike 21 other developed nations, the United States does not have a national health program which provides medical care to virtually all of its population. (U.S. Department of Health and Human Services, 1987)

- In 1987, 37 million non-elderly Americans had no health insurance. Of these, more than 12 million were children, a 14% increase since 1981. (Swartz, 1989; American Academy of Pediatrics, 1989)

- Babies whose parents have no health insurance are 30% more likely than those from insured families to die or be seriously ill at birth, according to a study of more than 100,000 births in the San Francisco Bay area. (Braveman, 1989)

- Uninsured low-income children receive 40-50% less physician and hospital care than low-income insured children. (Rosenbaum, 1987)

U.S. HEALTH SYSTEM MORE COSTLY THAN IN COMPARABLE NATIONS

- In 1984, the U.S. ranked highest in total health expenditures as a percent of gross domestic product (GDP) among 23 Organization for Economic Co-operation and Development countries, including Western Europe, Australia, Canada, and Japan. The United States allocated 10.7% of its GDP to health expenses compared with 8.4% in Canada and 5.9% in the United Kingdom. [Organization for Economic Co-operation and Development (OECD), 1987]

- Public expenditures as a percent of total health spending were lower in the U.S. than in any of the same 23 OECD countries. In the U.S., 41% of total health expenditures were paid by the government, compared with 74% in Canada and 72% in Japan. (OECD, 1987)

ECONOMIC WELL-BEING OF CHILDREN MORE PRECARIOUS IN U.S.; LOW-INCOME CHILDREN HAVE POOR HEALTH OUTCOMES

- In 1979, 17% of all children in the United States were living in poverty, a child poverty rate that was nearly 80% higher than in Canada (9.6%), and more than twice the rate in West Germany (8.2%) and Sweden (5.1%). [Select Committee on Children, Youth, and Families, U.S. Bureau of the Census data (Census), 1990]

- In 1979-1981, at least 99% of poor families with children received government assistance in Sweden, West Germany, Australia, Canada, and the United Kingdom, compared with only 73% of poor families in the United States. (Census, 1990)

- Low-income children in the U.S. are about twice as likely as higher income children to be born at low birthweight, two to three times more likely to experience postneonatal mortality, and three times more likely to have delayed immunizations and lead poisoning. (Starfield and Newacheck, 1986)

- Children in poverty are almost 50% more likely to have a disability than children from higher income families. (Fox, 1987)

INFANT HEALTH MORE FAVORABLE IN EUROPE AND CANADA THAN IN U.S.

- Each year, nearly 40,000 infants die in the United States before their 1st birthday. In 1987, the infant mortality rate was 10.1 deaths per 1,000 live births. The U.S. ranks behind 21 other industrialized nations in its infant mortality rate. (National Center for Health Statistics, 1989; U.S. Public Health Service, 1989)

- In 1982, 6.8% of infants were born at low birthweight (LBW) in the United States, 60% higher than in Norway and Sweden (4.1% and 4.2%) and also higher than in France, West Germany, Canada, Italy, and the United Kingdom. A low birthweight infant is 40 times more likely to die in the first month of life than normal weight infants. In 1987, the U.S. LBW rate rose to 6.9%, the highest level observed since 1979. (Census, 1990; Institute of Medicine, 1985; National Center for Health Statistics, 1989)

- In 1986, the U.S. ranked 16th among 20 industrialized nations in deaths to infants under age one who survived the 1st month of life. The U.S. postneonatal mortality rate (3.6 deaths per 1,000 live births) was 28% higher than in Canada (2.8) and 20% higher than in the Netherlands (3.0). The rate for U.S. blacks (6.3) was twice the U.S. white rate (3.1) and 50% higher than in England and Wales (4.3). (Kleinman and Kiely, 1990)

- Sudden infant death syndrome (SIDS) was the leading cause of postneonatal mortality in each of five European countries, the U.S. and Canada in 1986. Although the U.S. SIDS rate (131 deaths per 100,000 live births) was lower than in England and Wales (195), Norway (190), and France, (158), the U.S. black rate (215) was higher than in each of these countries and 87% higher than the U.S. white rate (115). (Kleinman and Kiely, 1990)

- U.S. black infants are at least three times more likely to die from respiratory disease in the postneonatal period than babies in Canada, France, and Norway, and are more than twice as likely to die as a result of perinatal conditions than infants in Canada, France, and the Netherlands. (Kleinman and Kiely, 1990)

YOUNG U.S. CHILDREN LACK PROTECTION AGAINST CHILDHOOD DISEASES

- Immunization rates for preschool children against diphtheria, tetanus, and pertussis (DTP) average 41% higher in many Western European countries than in the United States, and mean polio immunization rates are 67% above U.S. figures. (Williams, 1990)

- In 1985, 61% of U.S. preschool children were immunized against measles. Though this rate was higher than those of West Germany and France (an estimated 50% and 55%), it was 30-50% lower than in Denmark, Norway, and the Netherlands. (Williams, 1990)

VIOLENCE/ACCIDENTS HIGH AMONG U.S. CHILDREN AND YOUTH

- Among U.S. children ages 1 to 4, motor vehicle accident mortality rates for males (8.0 per 100,000) range from 36%

greater to more than three times those reported by France, Canada, England and Wales, Norway, and the Netherlands, (5.9, 4.3, 3.4, 3.2, and 2.4 respectively in 1984 to 1986). (Williams and Kotch, 1990)

- In 1986, more than three-fourths of all deaths to youth in the United States, Canada, and Sweden were due to accidents, suicide, homicide, or other violence, with the highest proportion in the United States, 78%. (Census, 1990)

- Male youth in the United States are more than 5 to 11 times more likely to be victims of homicide than in most other industrial countries. (Census, 1990)

U.S. TEEN FERTILITY AMONG HIGHEST IN INDUSTRIALIZED WORLD

- Among 13 industrialized countries, teenage fertility is highest in Hungary and the United States (52 and 51 births per 1,000 women ages 15-19, respectively), followed by the Soviet Union (44), the United Kingdom (29), Israel (25), and Canada (24), and lowest in Japan (4). (Census, 1990)

- In 1982, 10% of teenage women (ages 15-19) in the U.S. became pregnant. Among other developed countries, teenage pregnancy rates ranged from 1% in Japan to 8% in Hungary. (Census, 1990)

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Chairman MILLER. With that I'd like to recognize the ranking minority member, Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. Peter Drucker, one of the foremost authorities on management theory today, has written that "the most common source of mistakes in management decisions is the emphasis on finding the right answer rather than the right question." I hope that we will keep Mr. Drucker's wisdom in mind throughout this hearing. If we do, today's hearing and the committee's report on an international comparison of children's well-being, which was just released, will be useful.

If we cross that line and convince ourselves that there are easy answers in these two efforts just waiting to be plucked, we will have failed the lesson.

The report does add further evidence that we cannot separate what is happening to children from what is happening within their families. The report clearly demonstrates that poverty among single-parent families is an international experience.

The single most instructive statistic in the report shows that the United States has the highest proportion of single-parent families. The United States has more children living in poverty because it has more children living in single-parent families. While 22.9 percent of family households in the United States are headed by a single parent, less than 6 percent of households in Japan are headed by a single parent.

If we are to truly re-evaluate our national policies regarding children, this is where we must start. Here are the first questions to be asked. Why are one in five families with children missing a parent? Did government cause this to happen? Can government correct this situation?

This factor has widespread implications for many other health and welfare indicators, including infant mortality rates, teenage pregnancy rates, abortions, out-of-wedlock births and educational achievement. Family life is a critical predictor of child health status. Studies in the United States have found that unmarried mothers are more than three times as likely as married mothers to obtain late or no prenatal care. Children living with only one parent are twice as likely to be without health insurance as children in two-parent families.

Financial means alone does not determine health outcomes. Studies of refugees in the United States show that even the poorest of the poor have healthy babies if the family support system is intact. Thus, we find that good child policies begin with the family. If you're going to compare our infant mortality rate to Japan's, start by looking at the teenage pregnancy rate. The teen pregnancy rate in Japan is 10 per 1,000 women, compared to 98 per 1,000 women in the United States.

The real trouble we face is in the way we think about the problem. It is difficult to believe that the solution for improving child health demands more money when the United States spends a greater percentage of Gross Domestic Product on health care than any other country we have studied. Federal, state and local governments will spend an estimated $70 billion this year on needs-tested medical care. Perhaps, therefore, we are not asking the right questions.

We should use this report and hearing to question the performance of the health care delivery system. The components which are necessary to lower the preventable infant mortality rate are simple things. Why are pregnant women not receiving the services they need? Part of the answer lies in the fragmented, complex delivery system we have constructed. More than ever we intend to challenge the wasteful bureaucracy which consumes much of the resources meant to serve people.

We indeed live in a global village, but we cannot assume that the lives and health of children can be interpreted without regard to the basic unit of the village—the family. It would be a serious mistake to attempt to formulate public policy by isolating the child from his or her family.

Thank you, Mr. Chairman.

[Prepared statement of Hon. Thomas J. Bliley, Jr. follows:]

OPENING STATEMENT OF HON. THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA, AND RANKING REPUBLICAN MEMBER

CHILD HEALTH: LESSONS FROM DEVELOPED NATIONS

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Thus, we find that good child policies begin with the family. If you are going to compare our infant mortality rate to Japan's, start by looking at the teenage pregnancy rate. The teen pregnancy rate in Japan is 10 per 1,000 women compared to 98 per 1,000 women in the United States.

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CHILD HEALTH: LESSONS FROM DEVELOPED NATIONS

Minority Fact Sheet

March 20, 1990

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PROGRESS IN CHILD HEALTH IN THE UNITED STATES

Infants

The progress in reducing the infant mortality rate in the United States is a mixed story. Although the rate infant deaths (under 1 year of age) has been reduced from 20.0 percent in 1969 to 9.9 percent today, much of the success in recent years is attributable to high technology. As the graph below shows, the decline in the infant mortality rate has slowed.

The incidence of low birthweight (LBW) is an important indicator of infant morbidity and mortality. From 1975 through 1987, the overall incidence of low birthweight declined by 6.6 percent. Although LBW declined for both white and black infants, the decline was substantially slower for black (2.9%) than for white infants (9.3%).

LOW BIRTHWEIGHT - United States, 1975-1987
(Rates per 1,000 live births; Less than 2,500 grams)

Year	All Races	White	Black
1975	73.9	62.6	130.9
1980	68.4	57.0	124.9
1985	67.5	56.4	124.2
1987	69.0	56.8	127.1

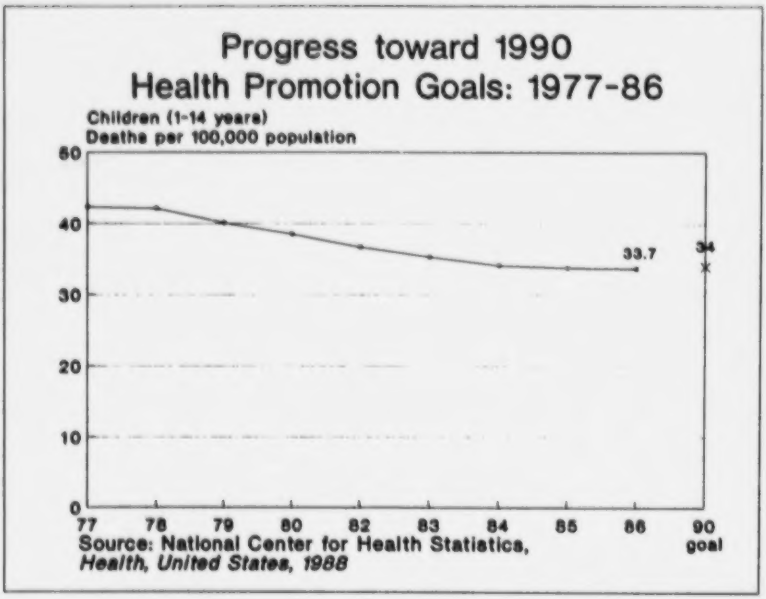
[Centers for Disease Control: **Morbidity and Mortality Weekly Report**, March 9, 1990/Vol. 39/No.9, p. 149. Public Health Service, US DHHS]

o "From 1981 through 1985, the rate for full-term LBW infants declined by 7%, but the rate for preterm LBW infants increased by 2%." [CDC. p. 149]

o The decline in the overall rate of LBW is due to the reduction in the rate of full-term LBW infants. In comparing births by gestational period, we find greater improvement among black infants than white infants. Although preterm black infants have a higher incidence of LBW than white infants, black infants which are are carried to term (greater than 37 weeks gestation) have a lower incidence of LBW. The greatest declines in low birthweight and very low birthweight (less than 1,500 grams) are for full-term black infants. [CDC. p. 149.]

Children Ages 1-14

In 1979, the United States Public Health Service adopted a health promotion goal to reduce deaths among children ages 1 to 14 years by at least 20 percent to fewer than 34 per 100,000 by the year 1990. As the graph below shows, this goal has been met.



o Between 1970 and 1986, the death rate for children aged 1-4 declined by 38 percent from 84.5 per 100,000 to 52 per 100,000. The death rate for children aged 5-14 declined by 37 percent over this same period, from 41.3 to 26.0 per 100,000. [National Center for Health Statistics: Health, United States, 1988. DHHS Pub. No. (PHS) 89-1232. Public Health Service, Mar. 1989. p. 61.]

o Nearly all U.S. children are now immunized by the time they start school. According to the U. S. Department of Health and Human Services, the U.S. has exceeded its 1990 national health objective of a 95 percent vaccination rate against measles, mumps, rubella, polio, and DPT for kindergarten/1st grade children. As of the 1984-85 school year, Head Start programs and licensed day care centers reported immunization levels of 93% or higher, and kindergarten through 1st grade school entrants had levels above 96%. [U.S. Dept. of Health and Human Services, PHS: The 1990 Health Objectives for the Nation: A Midcourse Review, 1986]

SELECTED NOTIFIABLE DISEASE RATES - United States, 1950-1987
(cases per 100,000 population)

Disease	1950	1960	1970	1980	1985	1987
Diptheria	3.83	0.51	0.00	0.00	0.00	0.00
Mumps	----	----	85.85	3.86	1.30	5.43
Pertussis (whooping cough)	79.82	8.23	2.08	0.76	1.50	1.16
Poliomyelitis	22.02	1.40	0.02	0.00	0.00	0.00
Rubeola (measles)	211.01	249.42	23.23	5.96	1.18	1.50
Rubella (German measles)	----	----	27.75	1.72	0.26	0.13

[National Center for Health Statistics: Health, United States, 1988. DHHS Pub. No. (PHS) 89-1232. Public Health Service, Mar. 1989. p. 81.]

o The dramatic decline in childhood diseases since 1950 is a factor which should not be overlooked nor taken for granted. Preventive health strategies have demonstrated their value as the eradication of these childhood diseases has improved the health of our children. But as the recent increases in mumps and whooping cough show, vigilance is always required.

Children and Young Adults Ages 15-24

o The death rate for children and young adults ages 15-24 declined by 20 percent between 1970 and 1986. [National Center for Health Statistics. p. 61.]

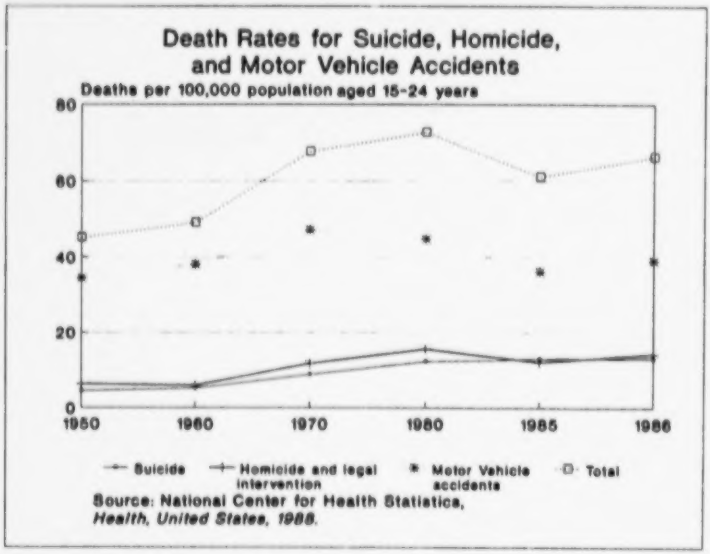
o Within this age group, there are interesting differences which defy simple explanation. Since 1970, the death rate has declined most rapidly for black females, by 43 percent.

DEATH RATES FOR CHILDREN AND YOUNG ADULTS AGES 15-24
1950-1986
(Deaths per 100,000 resident population)

Sex/Race	1950	1960	1970	1980	1986
All	128.1	106.3	127.7	115.4	102.3
White Males	152.4	143.7	170.8	167.0	145.9
Black Males	289.7	212.0	320.6	209.1	190.5
White Females	71.5	54.9	61.6	55.5	50.4
Black Females	213.1	107.5	111.9	70.5	64.3

[National Center for Health Statistics. p. 61.]

o While the death rate for all causes has declined, there are some disturbing exceptions in specific causes of death for this population. The following graph plots the history of death rates for suicide, homicide, and motor vehicle accidents for the population ages 15-24 for the years 1950-1986.



Source: National Center for Health Statistics, *Health, United States, 1988.*

o Between 1970 and 1980, there was a 33 percent increase in the death rate by homocide and legal intervention. Although this indicator declined in the early 1980s, it has increased again. Thus, the overall death rate for this category increased by 21 percent between 1970 and 1986. [National Center for Health Statistics p. 73.]

o Although the homicide rate for black males continues to be the highest among subgroups (gender, race) the death rate for black males has actually declined by 23 percent. White males have experienced the greatest increase, 58 percent. [National Center for Health Statistics p. 73]

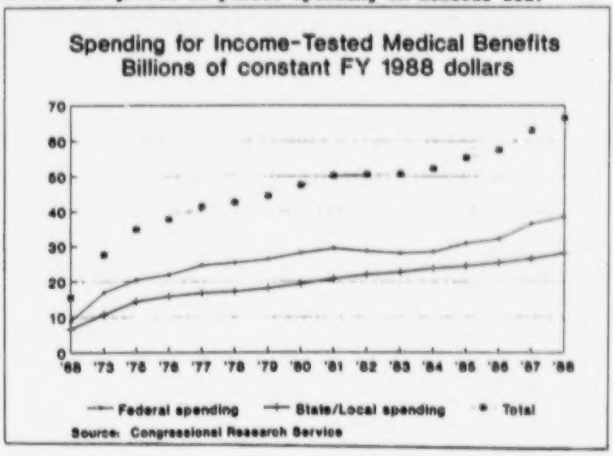
o The suicide rate has increased by nearly 50 percent for this age group since 1970. Although the suicide rate for females, black and white, has declined, the rate for black males has increased by 9.5 percent and by nearly 70 percent for white males ages 15-24. [National Center for Health Statistics p. 74.]

o The death rate for motor vehicle accidents declined by 17 percent between 1970 and 1986. Among the sex and race groups, the death rate is highest for white males (62.6%). [National Center for Health Statistics p. 72.]

PUBLIC HEALTH CARE RESOURCES FOR CHILDREN

Spending

o Federal and state and local governments spent $173 billion on all income-tested benefits in 1988. In constant dollars, this is a 235 percent increase since 1968. Spending on income-tested medical aid increased 332 percent in this same period. Medical aid now accounts for 38 percent of the needs-tested benefit package. The graph below illustrates the growth in public spending on medical aid.



Programs

o The Select Committee recently released a report, **Federal Programs Affecting Children and Their Families, 1990**, which describes 18 different Federal health programs for children. These are:

Medicaid
Maternal and Child Health Services Block Grant
Community Health Centers
Preventive Health and Health Services Block Grant
Childhood Immunization
Emergency Medical Services for Children
Family Planning
Alcohol, Drug Abuse, and Mental Health Block Grant
Hight Risk Youth Demonstration Grant Program
Community Youth Activity Program
Demonstration Grant Program for Pregnant and Postpartum Women and Their Infants
Pediatric AIDS Health Care Demonstration Program
Indian Health Program
Indian Health Service Substance Abuse Services for Youth
Migrant Health Program
Federal Employees Health Benefits Program
Military Health Care Services
Civilian Health and Medical Program of the Department of Veterans' Affairs (CHAMPUS)

LESSONS FOR THE EXISTING MATERNAL AND CHILD HEALTH SYSTEM

The United States spends a greater percentage of its Gross Domestic Product on health care than any other developed country. Two factors should be considered in any potential reform: family status and administrative organization of the existing publicly-financed maternal and child health care system.

o "Unmarried mothers are more than three times as likely as married mothers to obtain late or no prenatal care. Unmarried white mothers are almost four times as likely as married white mothers to obtain late or no care; and unmarried black mothers are twice as likely as married black mothers to obtain late or no care." [**Prenatal Care: Reaching Mothers, Reaching Infants.** Institute of Medicine, 1988, pp. 38-39.]

o "Family income is the most important determinant of health insurance status for all ages. Adolescents in poor or near-poor families are much more likely to be uninsured; approximately 30 percent are without any coverage, public or private." [Office of Technology Assessment, **Adolescent Health Insurance Status**, July 1989. p. 13.]

o "Most adolescents who live with only one parent live in or near poverty: 60 percent of adolescents who live with their mother only are in families below 150 percent of poverty. Adolescents who do not live

with a parent at all are even more likely to live in or near poverty. In contrast, only 16.2 percent of adolescents in two-parent families live below 150 percent of poverty." [OTA, p. 16.]

o Nearly 90 percent of adolescents age 10-18 who live with two parents have health insurance coverage. [OTA, p. 62]

o Most major child health problems can be overcome without substantial new costs by using existing knowledge: "We must recognize that most of the world's major health problems and premature deaths are preventable through changes in human behaviour and at low cost. We have the know-how and technology, but they have to be transformed into effective action at the community level." Dr. Hiroshi Nakajima, WHO Director-General [**The State of the World's Children, 1990.** UNICEF: Oxford Univ. Press, p.14]

o Complex programs in a fragmented system are barriers instead of gateways to access: "Although a low-income woman may now be 'entitled' to prenatal care services under Medicaid, she often faces a cumbersome eligibility process, long waits for appointments, inhospitable conditions at health care sites, or no means of transportation to appointments." [**Troubling Trends: The Health of America's Next Generation.** National Commission to Prevent Infant Mortality, Feb. 1990, pp.6-7]

o Our existing maternal and child health system is difficult to administer: "Even when fully funded,...programs are difficult to coordinate because they are often independent of one another (with) separate administering agencies, rules, and guidelines..." [**Prenatal Care: Reaching Mothers, Reaching Infants.** Institute of Medicine, 1988, pp. 70.]

o "WIC services and prenatal care are not routinely coordinated. ...(l)ow rates of participation were attributed to many of the same barriers to coordination that exist between Medicaid and publicly financed prenatal services." (Institute of Medicine. p. 70-71.)

o Gaps in services stem from non-integrated programs: "Another important example of poor linkage is the gap between pregnancy testing and prenatal care. This gap can be associated with major delays in beginning prenatal care." (Institute of Medicine. p. 71.)

Chairman MILLER. Thank you. I would ask unanimous consent that my full opening statement be placed in the record. I would also like to just say that this hearing is held in conjunction with the Conference on Cross-National Comparisons of Child Health taking place this week, sponsored by the American Academy of Pediatrics, the National Commission on Children and the National Commission to Prevent Infant Mortality, as well as the select committee.

Joining us today is Senator Lawton Chiles, who is the chairman of the Commission to Prevent Infant Mortality. Welcome, Lawton, to the Committee. You also have a statement that we will place in the record.

Mr. CHILES. Thank you, Mr. Chairman. I particularly want to thank you and Congressman Bliley for all of the work that you've done in regard to children and the outstanding work of your committee. I thank you for allowing me to participate and for graciously allowing me to be up here.

I think you were one of many Members of the House who frequently asserted that I tried to run the affairs of the House during the 18 years that I was in the Senate, and now you're giving me a chance to come up here and sit on this side of the aisle.

A few weeks ago the National Commission to Prevent Infant Mortality released a report, "Troubling Trends: The Health of America's Next Generation." That report documented a continuing high infant mortality rate for our Nation, and a stagnating low birth weight rate and a growing black and white infant mortality gap, an increasing number of high-risk mothers and inadequate prenatal care.

Clearly we need to learn from other developed nations some successful strategies for reversing these trends. In February of 1988, our commission held a hearing in the United Nations for a similar purpose to today's hearing. The hearing focused on the international infant mortality comparisons. Today your focus is broader on the health of all children, but I notice that a number of your distinguished panel members were also there and helped to educate us at the time that we held our hearing.

We did look at the health care systems and related social services of other nations for one main reason, because we have fallen behind other nations in infant health, despite the sophistication and excellent health care available and a high percentage of our income spent on health. What much of that testimony suggested was that medical technology may have reached its limits in reducing infant mortality, that high technology medicine has reached a plateau in its ability to save smaller and smaller infants, and that further progress in improving infant health will result rather from improved social support provided to all pregnant women and infants in conjunction with good health care.

Summarizing just a few of those, we find that many nations offer incentives, financial and otherwise, to encourage their pregnant populations to attend prenatal maternal care. Many nations have child health handbooks. Japan gives it to pregnant women immediately when they become pregnant and the use of the handbook is a conscious effort to empower parents with the knowledge and means to improve their health.

Home visiting is a feature of almost every country's maternal care system. The home visit is an opportunity to educate new mothers about nutrition, well-baby care, immunizations and even about whether they need to have future and frequent pregnancy repeats after that. Integrated services, making a wide array of health and social services available, a one-stop shopping approach enhances access, universal access to services. We find that other nations are making far more progress in reducing the financial and other barriers to care for pregnant women and their infants. Ten European nations, we found, offer a full range of perinatal support services free of charge to women of all social and economic levels. Provisions for working women, offering provisions to pregnant women to protect the fetus, the newborn and the mother from specific harmful effects of work, protect the mother's employment, provide income maintenance for parents during breaks in employment.

I certainly look forward to listening to this distinguished panel of experts that you have today, Mr. Chairman.

[Prepared statement of Senator Lawton Chiles [retired] follows:]

OPENING STATEMENT OF SENATOR LAWTON CHILES (RET.), CHAIRMAN, NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, WASHINGTON, DC

Mr. Chairman: I would like to thank the Committee for holding this hearing on lessons we can learn from other nations on Child Health. I particularly thank the Chairman for graciously allowing me to participate.

A few weeks ago, the National Commission to Prevent Infant Mortality released a report called "Troubling Trends: The Health of America's Next Generation." That report documented a continued high infant mortality rate for our nation, a stagnating low birthweight rate, a growing black-white infant mortality gap, an increased number of high-risk mothers, and inadequate prenatal care. Clearly we need to learn from other developed nations some successful strategies for reversing these trends.

On February 2, 1988, the National Commission to Prevent Infant Mortality held a hearing at the United Nations with a similar purpose to today's hearing. The hearing focused on "International Infant Mortality Comparisons". Although our focus today is broader—on the health of all children—I would like to take a few minutes to review some of the lessons we learned two years ago—lessons that we still have not heeded.

We looked at the health care systems and related social services of other nations for one main reason—because the United States has fallen behind other nations in infant health, despite the sophistication and excellence of health care available and the high percentage of income spent on health.

What much of the testimony suggested was that medical technology may have reached its limit in reducing infant mortality—that is, high-technology medicine has reached a plateau in its ability to save smaller and smaller infants. Further progress in improving infant health will result, instead, from improved social supports provided to all pregnant women and infants in conjunction with good health care.

I'd like to summarize a few of the social support services and strategies that other nations are employing to reduce infant mortality:

Incentives for Prenatal Care Attendance: Many nations offer incentives, financial or otherwise, to encourage their pregnant population to attend prenatal care.

Maternal and Child Health Handbooks: Continuity of care is often facilitated by having pregnant women carry their health care records with them. In several countries, notably Japan, such handbooks are given to pregnant women immediately when they become pregnant. The use of a handbook is a conscious effort to empower parents with the knowledge and the means to improve their health and that of their children.

Home Visiting: Home visiting is a feature of almost every country's maternity care system. The home visit is seen as an opportunity to educate new mothers about nutrition, well baby care, immunizations, and other important health measures.

Integrated Services: Making a wide array of health and social services available to women and children at one location is common in many countries. This one-stop shopping approach enhances access to care by reducing geographic and bureaucratic barriers.

Universal Access to Services: Other nations are making far more progress in reducing the financial barriers to care for pregnant women and their infants. Ten European nations, we found, offer a full range of perinatal support services free of charge to women of all socio-economic levels.

Provisions for Working Women: Most other nations offer legal, administrative, and financial support to pregnant women to (1) protect the fetus, newborn, and mother from any specific harmful effects of work, (2) protect the mother's employment, and (3) provide income maintenance for parents during breaks in employment.

I look forward to hearing from the experts testifying today to hear their views on innovative aspects of their countries' child health policies that result in good outcomes. I am particularly interested in seeing how their recommendations for the health of children compare to those for reducing infant mortality. I believe the United States has many lessons to learn and I hope that your collective experience can help guide us in correcting the faults of our system and providing health and support services for all our children.

Chairman MILLER. Thank you. With that, we'll begin. We can have the panel come forward. We'll hear from Dr. Birt Harvey, who is the president of the American Academy of Pediatrics, California; Shirley Goodwin, who is the General Secretary, Health Visitors Association from England; Dr. I. Barry Pless, who is a professor, Department of Pediatrics from Montreal, Canada; Michel Manciaux is a professor of Public Health and Social Pediatrics in France; Sverre Lie, who is a professor, Department of Pediatrics from Norway; Hans Verbrugge, who is the Medical Officer of Maternal and Child Health Care from The Netherlands; C. Arden Miller, who is a professor of Maternal and Child Health from North Carolina.

If you would come forward to the committee table. First of all we will begin by thanking you for your time and your willingness to testify today and to welcome you to the committee. We look forward to your testimony. Your written statements and supporting documents will be placed in the record in their entirety, and you should proceed in the manner in which you're most comfortable. This is a pretty relaxed committee, so you don't have to worry about all of the formalities.

Before we begin, I would also like to acknowledge the presence of Marsden Wagner, who is the director of Maternal and Child Health for the World Health Organization, the European Region, who is with us but will not be testifying.

Congressman Martinez has joined us. Do you have a statement you want to make?

Mr. MARTINEZ. No, I don't.

Chairman MILLER. We'll begin, Dr. Harvey, with you.

STATEMENT OF BIRT HARVEY, M.D., F.A.A.P., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, PALO ALTO, CA

Dr. HARVEY. Mr. Chairman, Members of the committee, Senator Chiles, thank you very much for the opportunity to appear before you.

As you know, we have just held the Cross National Child Health Comparison Conference to try to learn what in European nations and Canada might be applicable to our health care delivery so that we might improve the health of the children of this nation.

We all know that in infant mortality, we are either nineteenth or twenty-second, depending upon whose statistics you wish to use. The question is where do we stand in other indicators of child health. Are we behind, or are we ahead in other ways? Is there anything we can learn? We did find that in many other ways we are behind; it's not just in infant mortality.

I'm going to mention just a few examples, but my colleagues from the European nations and Canada will give you more details and more ideas.

In immunizations, if we compare the status of our children with children in Europe and Canada, we are far behind. If we look just at DPT (diphtheria, tetanus, and whooping cough vaccinations) in the Netherlands 97 percent of children are immunized by age 3. In Norway, 90 percent are immunized by age 3. If we look at our country, 65 percent are immunized by age 4.

Very often it's said, "Well, this is related to a much greater minority population in this country," but if we look at just the white population of this country, which gives us a proxy for the middle class, it's only 69 percent that are immunized against DPT by age four. The same holds true for measles and for polio; we're far behind.

What we've seen in this last year because of this problem are epidemics of measles in many cities throughout this nation. In your state of California, Mr. Miller and Mr. Martinez, there have been huge epidemics in Los Angeles and Fresno and elsewhere. It's a tragedy. There have been 40 deaths from measles in U.S. children during this year. This was a disease we had predicted would be totally eradicated by the year 2000, even earlier than that. We're not going to achieve it.

We often also say, "Well, we're a more heterogeneous nation in other ways; we've got a much bigger rural area, and that's why we have trouble compared to European nations where there may be great population density." We specifically invited Dr. Lie from Norway to the conference, so that we could see how Norway manages because it is far more rural than any state in this nation, and yet 80 percent of their children are immunized for DPT by the time they are three.

We learned something that the Netherlands does. Shortly after a child is born, the mother receives a series of computer cards with the dates and locations where she should take her infant for his or her immunizations.

If the mother doesn't show with the child, she is called. They have that computerized. If she doesn't respond to two calls, they send a nurse out to the home to see that the child gets immunized.

If we look at another area, post-neonatal mortality, which is the death rate of children from age one month to one year, we have slipped. In 1950, we were third in the world. In 1986, we were sixteenth. If we just look at the white population of this country, so that the question of minorities may not be raised, we have still slipped from third to tenth in that period of time.

Post-neonatal mortality is really a proxy for access to care for children. We know very well that when children don't have access to care, there are decreased visits to health facilities, and there are higher mortality and morbidity rates in those children. Currently,

we know that somewhere between 10 and 13 million children in this country have no health insurance whatsoever. This is in contrast to all the other nations represented at the Cross National Conference and every developed nation in this world other than South Africa.

Access to care may be a cornerstone, but it's only part of the child health policy that we need in this country. Really what we need is a children's policy, not a child health policy. One thing we learned this week is that you can't really separate medical care out as part of health because health is much greater than medical care. Health is interrelated with nutrition, with early childhood development, and with appropriate day care. It's interrelated with education; it's interrelated with parental leave after delivery or when children are sick.

You in your wisdom in Congress recognized this when you passed the Education for All Handicapped 94-142 and then with its amendments, 99-457. You can't separate health from education. Children have to be healthy to be able to receive a decent education.

In a recent report from the Carnegie Foundation, 70 percent of U.S. teachers said that they had students whose health status or nutrition status interfered with those children being able to get a decent education.

Anyway, if we look toward a children's policy, at least we could start with a child health policy. We could develop goals that we want to achieve for children. We could develop priorities, and we could allocate our resources more appropriately.

As you point out, Congressman Bliley, we could decrease fragmentation. That certainly is appropriate to look at. But at the same time we decrease fragmentation and get a more organized administrative and delivery system with fewer categorical programs, we do need to set standards that states must follow. We do need to have surveillance, and we do need to collect appropriate data so that we can tell what the status of children is and how we are moving toward achieving goals.

You know, we really can judge our nation not by its military might, but by how it treats the poorest, the most vulnerable, the weakest of its citizens, and the children of this nation certainly fall into that category.

Thank you.

[Prepared statement of Birt Harvey follows:]

PREPARED STATEMENT OF BIRT HARVEY, M.D., F.A.A.P., PRESIDENT, AMERICAN ACADEMY OF PEDIATRICS, PALO ALTO, CA

Mr. Chairman, members of the Committee, I am Birt Harvey, president of the American Academy of Pediatrics. I am also clinical professor of pediatrics at Stanford University and clinical professor of pediatrics at University of California, San Francisco. Currently I serve as a senior fellow at the Institute of Health Policy Studies at the University of California in San Francisco.

Today you have the opportunity to hear from child health experts representing five other developed nations. Along with approximately 150 leaders in child health, business, public policy, education, and philanthropy, they have just participated in a conference examining health status of children in the United States and other developed nations.

For years we have known that our infant mortality rate places us far behind most other developed nations. One of the objectives of the conference was to learn whether this is an aberration or part of a more generalized trend. Therefore, other indicators of child health status were compared:

- *immunization rates, because they tell us about preventive care;
- *death rates during the postneonatal period (age one month to one year), because they tell us about access to care for illness; and
- *rates of unintentional injury, because they tell us about public health policy related to such matters as drowning, burns, firearms and motor vehicles.

Because our large minority population is often cited as a reason for our comparatively poor child health status, we broke down the United States data so that white children, as well as the entire child population, could be compared. Where possible we used factors other than race to further break down data.

Another often cited reason for disparity in health status measurements is the relative population density of the European countries compared to the United States. For this reason Norway was among the invited nations; its population is more rural and more difficult to reach than that of any of our states.

The purpose of the conference, Mr. Chairman, was not just to compare health status but to learn from the comparisons. Do other nations have child health policies? How do they deliver preventive care and acute illness care? How do they manage children who are at high risk -- those who are deaf, paraplegic, or developmentally delayed and those at

psychosocial or environmental risk? How do they manage the problems of the teenage years? What public health policies directly effect the health status of their children? How do they administer and finance child health services?

We have learned of some interesting programs and policies which might be applicable in the United States. You will hear about them today directly from the experts of these nations, but I would like to point out a few areas in which the health status of our children is inferior and possible reasons for the difference.

First, although we have high immunization rates for children entering school, rates among children under age four for diptheria, tetanus, and whooping cough average 41 percent higher, and for polio, 67 percent higher in our guest countries than in the United States. For example, the DTP rate is 97 percent in the Netherlands and 80 percent in Norway, whereas in the United States the overall rate is 65 percent and the rate for white children is 69 percent. Similar data can be presented for polio and measles. Is it any wonder that in this past year we have witnessed measles epidemics resulting in the deaths of 40 children?

What can we learn from other developed nations? England and Wales are developing computerized tracking of immunization with quarterly reports from 210 districts, each of which has an immunization coordinator. The Netherlands links a surveillance system to birth records. Shortly after birth parents are given computer cards with dates and locations for receiving necessary immunizations. If they fail to show they are called. If they still fail to show after two calls, a nurse goes to the home.

A second example is postneonatal mortality rates. In 1950 we ranked third in children older than one month and younger than one year. By 1986 we had fallen to 16th. If one looks only at the white population, we ranked 10th. Using proxies for socioeconomic status of a comparison of normal birth weight babies from higher and lower groups shows, that if children in the lower socioeconomic groups were to do as well as those in the highest group, a 50 percent reduction in preventable postneonatal deaths would occur, which brings us to the issue of access to care.

We know that children who do not have access to care use fewer health services and have poorer outcomes. Over the years other developed nations have instituted policies that assure access for all children. That may be the lesson for us. We must as a nation guarantee access to comprehensive health care for all of our children.

Rather than citing more programs I think it is better that we address how programs might be integrated into our child health system, or should I say our nonsystem. Our nation has no comprehensive policy regarding child health. We respond to crisis or to pressure from organizations interested in a specific disease, age, geographic, or economic group of children. The resultant multiple, categorical, non integrated programs only serve to fragment an inefficient system.

We have no national child health goals and no priorities. We have no high level administrator who can coordinate programs within the Department of Health and Human Services (DHHS). There is a lack of coordination not only within DHHS but among the various other departments that administer child health programs. There is no one in the White House or at DHHS who looks to see how various new programs may impact on children or who advocates for the needs of children.

What can we learn from these other nations? In addition to studying their specific programs, we can gather ideas that may help to improve and to integrate our administrative, delivery, and financing systems. We can learn about improving surveillance and data collection and about removing barriers to access to care for all children. As we adopt new programs, each should be integrated into an overall children's policy.

Meeting the health needs of our children is not only in our national interest but it is the proper role of those who develop health policy. We, as a nation, can best be judged not by our military might but by how we treat the weakest and least heard of our citizens. Children compromise most of that vulnerable category.

Chairman MILLER. Thank you. Ms. Goodwin.

STATEMENT OF SHIRLEY GOODWIN, B.Sc., RGN., RHV, GENERAL SECRETARY, HEALTH VISITOR'S ASSOCIATION, LONDON, ENGLAND

Ms. GOODWIN. Thank you, Mr. Chairman. I've chosen to speak to you today about the health visiting service in the United Kingdom, and specifically about its role in child health care.

The Health Visiting Service first came into existence during the second half of the last century in response to high levels of infant morbidity and mortality in some of our northern cities. By the beginning of this century it was provided by virtually every local authority as part of the Maternal and Child Health Services. In the early '70s, we became part of the National Health Service and, therefore, fell within the administrative framework of the health services, rather than the local authorities.

Health visitors are registered general nurses with additional public health training. They provide a health promotion and preventive health care service for all the residents of each local population, but there is a specific focus within their work on families with young children.

Each health visitor has the responsibility for the families who live within a particular geographical area, or registered upon the practice list of the family doctor, the general practitioner, with whom she may work as a member of the local primary health care team.

Her workload consists of home visits to and other individual and group contacts with the families who live on her patch, as well as other interventions such as local health education campaigns, the organization of support groups, involvement in community activities and so on.

Statutory notification of every birth to the district health authority insures that health visitors are informed, usually within three or four days of the birth, that a new baby has arrived. The relationship with the health visitor, between the health visitor and the family, is usually started prenatally because health visitors get to know about pregnancies through the GP and go and make contact, particularly, of course, with young single parents.

They visit every home on or around the tenth day after the birth to offer such information, advice, health education, social support as may be necessary and appropriate to that individual family. They have no legal right of entry to the home, but very few are not welcomed because the service is well-known, universal and, therefore, nonstigmatizing.

Subsequently a program of home visits by the health visitor and the family's attendance at child health clinics provided within pram-pushing distance in every neighborhood, enable educative and supportive contact to be maintained throughout the first years of life.

Until responsibility for preventive child care is handed over to the school nurse at four to five years of age, health visitors make visits either on request or on an unsolicited and routine basis, or to undertake specific age-related aspects of the child health surveil-

lance program, to encourage attendance for immunization, talk about nutrition, child accident prevention and to give information about other services, for example.

Part of the health visitor's task is to seek actively, to look out for families that may not yet have come to the attention of the GP, or are not known to the health authorities register of children, and particularly, of course, in areas where there is social difficulty.

In Britain at the moment we have a large and increasing number of homeless families. We have a population of gypsy or travelling families and in many areas, particularly in the cities, we have high levels of immigrant populations. They, of course, attract particular attention from health visitors who go out actively to find them, for example, looking for nappies on the washing line, talking to neighbors, asking hotel proprietors who has moved in recently.

Families at increased risk of health and social difficulty, or with special needs of one kind or another, receive a lot of extra attention from health visitors. While social workers, who are employed by the local authority's social work departments, do have statutory responsibility for things like child care, disability and job protection, it is usually the health visitors who maintain long-term and continuing relationships with families, and who have the most accurate and extensive knowledge of families' individual lifestyles and circumstances.

No charge is made to the users of the Health Visiting Service, and it's financed out of the general allocations made by government to health authorities. Each health authority decides for itself the level of expenditure on the staffing of the Health Visiting Service and, for example, on the numbers it chooses to send for training as health visitors each year.

Apart from salaries, the major cost of providing the service are the cars that are provided for health visitors to do their visiting.

If I can just briefly comment in conclusion on the value of the Health Visiting Service, since the service has existed for 128 years, and is available in every area as part of the National Health Service, it's not been possible to mount properly controlled trials of health visiting to discover whether it is actually having any effect.

Some research has been undertaken by manipulating aspects of the service in one area or with a specific client group and then comparing outcomes in an area or with a group of clients who have continued to receive the usual service. Some such studies do indicate measurable beneficial effects.

In relation, for example, to increased uptake of home safety advice, immunization, breast feeding rates and in the reduction of child hospital admissions, and in a reduction to injuries to children who are known to be at increased risk of child abuse.

In conclusion, I would simply like to emphasize the strengths of the Health Visiting Service as relevant to the United States population, and to your situation and the issues you're looking at now.

First of all, it's universal and nonstigmatizing. Even the Royal Family sees a health visitor. I know the health visitor who went to visit the Princess of Wales when she had William and Harry. They get little attention after that first visit, I might say, but everybody gets a visit.

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This universality insures a high level of acceptability on the part of all classes or races and, therefore, insures good coverage for the service and access to it. But within that universality, the Health Visiting Service is a very flexible one and highly adaptable to different needs in different areas and, therefore, can be used in special ways to deliver specialized services to those with particular health needs.

The way the service is increasingly working nowadays, rather than offering a standard program designed from the top down is to look at the needs of each local population, design an appropriate service and build in outcome measures which can be evaluated to see how the service is working.

I would just like to end by saying that while I believe the Health Visiting Service in Britain is responsible for anything we may have been able to achieve in improvements in child health, we have our problems, too, and we're not doing so well on some measures. Postneonatal mortality was mentioned by Birt Harvey, we have a serious problem there. Our low birth weight rate is stagnant also.

So we haven't actually managed to reach all the parts that need to be reached. Therefore, I would simply say that while the service is certainly effective and would be appropriate to your situation, it alone is not enough to solve the problems that face you and the children of this country.

Thank you, Mr. Chairman.

[Prepared statement of Shirley Goodwin follows:]

PREPARED STATEMENT OF SHIRLEY A. GOODWIN, B.Sc., RGN., RHV, GENERAL SECRETARY, HEALTH VISITOR'S ASSOCIATION, LONDON, ENGLAND

A brief description of the UK Health Visiting Service and its role in child health care

1. Historical Background

The health visiting service first came into existence during the second half of the last century in response to the high levels of infant morbidity and mortality occuring at that time. Initially established in some northern English cities, by the beginning of this century health visiting was provided in virtually all areas as part of the maternal and child health services of the local borough and county councils. In 1974, the service moved from the local authorities and became part of the reorganised National Health Service, falling within the administrative framework of health authorities.

2. Health visitors

Health visitors are registered general nurses with additional public health training obtained during a one year university or polytechnic-based course. Many also have obstetric or midwifery qualifications. The vast majority of health visitors are women (although the profession is open to men) and the average age of entry is approximately 31 years, indicating that many have post-RGN nursing experience and/or enter health visiting after a career break to raise a family. They are paid on a grade equivalent to ward sisters in sole charge (£13,738 - 15,900). Health visitors are led by nurse managers who account to directors of community nursing services or general health service managers of district health authorities.

3. The purpose and remit of the service

Health visitors provide a health promotion and preventive health care service for the residents of each local population. The traditional maternal and child health focus of the service is still reflected in the priority given to families with young children, although preventive work with adult client groups, and particularly elderly people, has become increasingly more significant in recent decades.

4. The work of health visitors

Each health visitor has the responsibility for the families living within a particular geographical area or registered upon the practice list of the general practitioner with whom she works in association as a member of the primary health care team. Her workload consists of home visits to and other individual and group contracts with the families on her "patch", as well as other interventions such as local health education campaigns, the organisation of support groups and involvement in community activities.

Statutory notification of every birth to the district health authority of residence ensures that health visitors are informed, usually within 3 or 4 days, of new babies in their areas. They visit every home on or around the tenth day after birth to offer such information, advice, health education and social support as may be necessary and appropriate. Health visitors have no legal right of entry but few are not welcomed, since the service is well-known, universal and therefore non-stigmatising.

Subsequently, a programme of home visits by the health visitor, and the family's attendance at child health clinics provided in each neighbourhood enable educative and supportive contact to be maintained throughout the first years of life. Until responsibility for preventive child health care is handed over to the school nurse at 4-5 years of age, health visitors make visits on request, on an unsolicited and routine basis, or to undertake specific aspects of the local child health surveillance programme, encourage attendance for immunisation and to offer age-related advice in relation to nutrition, child safety etc.

Families at increased risk of health or social difficulty or with special needs of one kind or another receive extra attention from health visitors. While social workers (employed by the local authority social services departments) have statutory responsibility for matters such as child care, disability and child protection, it is usually health visitors who maintain the long-term and continuing relationship with families and who often have the most accurate and extensive knowledge of their lifestyles and circumstances.

5. <u>The financing of the service</u>

No charge is made to the users of the health visiting service. It is financed out of the general allocations made by government to health authorities, and each health authority determines the relative level of expenditure on the staffing of the service and on the numbers of qualified nurses it chooses to second for training. Apart from salaries, the major cost of providing the service arises from mileage allowances or lease cars required by health visitors to make their visits.

6. The value of the health visiting service

Since the service has existed for over a century and is available in every area as part of the National Health Service, it has not been possible to mount properly controlled trials of health visiting. Some research has been undertaken by manipulating aspects of the service in one area or with a specific group of clients, and then comparing outcomes where clients have continued to receive the usual service. Such studies indicate beneficial measurable effects in relation, for example, to increased uptake of home safety advice, immunisation and breastfeeding, and in reduced hospital admissions and injuries to children known to be at increased risk of child abuse.

While the cost-benefit of health visiting may be difficult to show and the service is considered to be a relatively expensive one, there is nevertheless considerable support for the continuation of its preventive child health role. Health service managers and public health physicians recognise the value of a home visiting service which not only provides routine supportive contact for young families but which also, through this contact, monitors the health and welfare of children (particularly in those families having difficulty coping) and offers general encouragement in the uptake of services, such as immunisation.

Paediatricians and general practitioners value the expertise health visitors possess in normal child health, growth and development and their consequent ability to recognise deviation from the norm and take appropriate action.

Parents and consumer organisations value access to an advisory and supportive service which is offered to all from the highest to the lowest in the land, the provision of which requires no demonstration of some special need or difficulty. While there is no entitlement in law to any part of the National Health Service, people in Britain do seem to regard the health visiting service as something to which they have a right - even though they may criticise it on occasions (with some justification) for being insufficiently accessible or responsive, or for being too interfering.

7. A changing service

Health visitors themselves live in constant fear of the profession's imminent abolition, realising that their service is costly and that its outcome is difficult to demonstrate in cost benefit terms. The increasing financial constraints placed upon health authorities over the past decade or so threaten low profile preventive services more than high profile acute care: it may be less painful for a health authority, for example, not to train six health visitors as usual one year, than to shut down operating lists or close hospital beds.

Partly as a response to questions about health visiting's "affordability" and partly through a sincere desire to offer a more user-friendly and appropriate service, health visitors are presently reshaping their professional practice to relate the level and type of service they offer much more closely to the needs of the population served by each individual or team of health visitors. This means that less routine and unsolicited home visiting is being undertaken than in the past, although the service remains universal and accessible to all. Specific programmes of health promotion work are devised on the basis of the local community's health profile, and measurable outcomes determined in advance.

There is greater use of collective and group strategies for health promotion rather than the traditional total reliance on one-to-one contact. Health visitors believe that the latter approach risks "disabling" or "blaming the victim", and that appropriate political and community action to challenge adverse social and environmental conditions is likely to be as effective in improving people's health as anything they can achieve as individual health professionals.

Shirley Goodwin
March 1990

Chairman MILLER. Thank you very much. Dr. Pless.

STATEMENT OF I. BARRY PLESS, M.D., FRCP(C) PROFESSOR, DEPARTMENT OF PEDIATRICS AND EPIDEMIOLOGY, McGILL UNIVERSITY, MONTREAL, CANADA

Dr. PLESS. Thank you, Mr. Chairman, Members of the Committee, Senator Chiles.

In the Cross National Conference preceeding today's meeting, I described Canada's health care system as one that many believe to be "the best in the world." I freely admitted that apart from its essential payment features, however, there was little about it that focused exclusively on child health.

Canada, like yourselves, does not yet have a comprehensive national child health policy, although recently a call for the creation of such a policy has been made by the Canadian Institute of Child Health, which I chair. In spite of this serious shortcoming, Canada's achievements are certainly noteworthy, especially by comparison with those of the United States.

Some data that I've compiled based on vital statistics reports from the United States and Canada for the period from 1960, which covers the decade prior to the introduction of health insurance in Canada, to 1986, show that the net improvement in death rates for children was 10 percent better for children under one year of age, nine percent better for those 1 to 4 years of age, about 15 percent better for those 5 to 14 years, and nearly 12 percent better for those 15 to 19 years.

Percentages are difficult things for people to get their minds around, and I simply want to translate them for you by saying that they amount to, as you can well imagine, thousands upon thousands of lives that have been saved. These trends, of course, are not specific for all causes of death and they're especially marked for deaths due to injuries and, not surprisingly, homicide.

Now in the face of these figures, and in view of the fact that in most other respects, the delivery of medical care, both in terms of quantity and quality is remarkably similar in our neighboring lands, it seems essential that we ask why these differences exist.

As a physician and as a parent, I'm convinced that it has much to do with our national health insurance programs, which, as you know, provide full coverage for all medical and hospital expenses at no direct cost to the patient, or in this case the family. These are paid for out of general tax revenues at, I might say, a percentage of the gross national product considerably lower than yours.

As a scientist, however, I must confess that I cannot prove that Canada's insurance programs are alone responsible for these differences, or responsible in large part, or to what extent. I readily admit that there are many other factors that need to be considered, but the health insurance programs are unquestion bly a critical starting point.

Whenever I presented these figures that I've just described to you to American audiences, I am immediately reminded that you have many more blacks and many more poor than we do. Certainly it's true that the proportion of Canadians who are Inuit or status Indians does not approach the proportion of blacks in the United

States, but there would be some argument, perhaps about the comparative proportion of families in Canada who live in poverty.

Official Census Canada figures put the proportion of those with children at 20 percent, a figure not too different from yours. Even if I were to concede that the differences in proportions or severity of poverty were much greater—a strange argument coming from what I still think of as one of the richest nations in the world—even if conceded, it seems to me all the more reason for recommending, in the strongest possible terms, that some form of truly comprehensive health insurance for children is essential as part of the cure of the problem that we're talking about today.

Although I stated a moment ago that I could not mobilize strong scientific evidence to support this conclusion—that the differences in death rates among children are due to our health insurance—I can cite at least two studies, both originating from McGill, and one on which I was co-author, which irrefutably demonstrate that one critically important effect following the introduction of Medicare, that is medical insurance in Quebec and, no doubt, in all of Canada, was to narrow the gap in access to and use of services between the rich and poor. This is precisely what was intended.

We are a country that believes above all in equity, not pluralism, and this was a goal in the creation of these programs. Hence, it seems to me only reasonable to suggest that the more poor a nation has, the more compelling the case for health insurance. Equally compelling, however, are the effects that it has been shown to have on the near poor and even on the middle class.

Now I'll not recite all the evidence that has been provided, particularly in the last three or four years by health economists, whom I deeply respect, save to remind you that as I read that evidence there can be no doubt that our system has permitted Canada to control medical care costs far more effectively, far more cheaply in terms of total expenditures, than have you.

To me the bottom line is not, however, an economic argument; it's a simple plea based on the test of what any one of us, any one of you, ladies and gentlemen, would want for our own children, and that is the certainty, the certainty, that they would never be denied access to medical care that could prove critical, whether measured in terms of life and death, the reduction in morbidity, or the prevention of disease.

There is abundant evidence that although in the aggregate medicine alone cannot and should not lay claim to all the spectacular, truly spectacular improvements in child health that we've witnessed over the last quarter century, and the last 50 years to be sure, it has, nonetheless, played an essential role.

In my view, and in the view of most Canadians, no child should be denied the full benefits of what medicine has to offer because of the inability of his or her parents to pay for medical care. It was that deeply held personal conviction that forced me to leave an excellent position in the United States and to return to Canada in 1975, and it's a decision that I've never once regretted.

Thank you.

Chairman MILLER. Thank you very much. Mr. Manciaux.

STATEMENT OF MICHEL MANCIAUX, PROFESSOR OF PUBLIC HEALTH AND SOCIAL PEDIATRICS, UNIVERSITY OF NANCY, NANCY, FRANCE

Mr. MANCIAUX. Thank you, sir. Mr. Chairman, Members of the Committee, Senator Chiles, I will speak about day care, early schooling and health care in France.

A recent American report by the French-American Foundation referred to in the New York Times "France Far Ahead in Providing Child Care," describes a French system of preschool programs insisting on a child day care system largely based on early admittance to nursery school.

This deserves to be presented in a continuity, starting from pre- and postnatal paid leave for the mother, 6 weeks before, ten weeks after delivery, with a guarantee to be reemployed. This paid leave is extended to 3 months after the delivery of a third baby, and parents can also ask for an unpaid parental leave up to two years in order to bring up their child, again with insured reemployment.

The next step is a complex combination of various possibilities for caring on a day-to-day basis for infants and children under three. About 60 percent of children under three are cared for at home by their mother. The remaining 40 percent are cared for by relatives, mainly grandparents, licensed or unlicensed caretakers, creches, either collective or family creches, and nursery schools.

Allowances for young children for day care outside the home, for single parent families, 9.4 percent of all families with children, help families cover partly the day care expenses and refrain them from resorting to unlicensed caretakers. These allowances vary according to parents' resources and the number of children.

Health care is provided through the maternal and child health official system completely free of charge and organized by the local authorities at the departmental level, the department being a French territorial administrative division with an average population of half a million.

Family and various allowances distributed by social security for this purpose amounted, in 1987, to nearly $18 billion United States. When they reach three years of age, most of the French children go to the nursery school. About 40 percent of the 2 year olds attend already the school, and more than 90 percent of those over three.

The quoted report says,

> The noncompulsory preschool programs, which serve nearly 90 percent of French children three to five years old, offer language, arts, exercise, crafts and play. The system also features intensive training and fair compensation for preschool teachers and others who take care of young children, a free preventive health program for all young children, and attention to the architecture and safety of day care centers.

Between three and four, children attending school benefit from a health checkup, usually done by the MCH team, doctor, child nurse, psychologist, and consisting of physical examination, screening for hearing, vision, psychomotor abilities, language.

The MCH team discusses with the school team about the adaptation of the child to school, his difficulties, achievements. The parents, also involved in the process, are interviewed on their child's health problem and informed of the result of the visit. If there is any problem requiring any sort of medical care like immunization

to be completed or sensory defect to be confirmed by more refined examinations in order to be corrected, parents are advised to consult their family doctor or a specialist working in a hospital or private practice.

A letter is given to them for this physician and the MCH team makes sure that the needed follow-up is performed, which is done according to some evaluations in about 80 percent of the cases. In addition, in the year before the child is admitted to compulsory elementary school starting at six, he is again examined with nearly the same protocol.

However, this five-year examination is under the responsibility of the school health team who takes over the MCH team with, of course, due coordination between both. This latter check-up is mainly aiming at screening for any developmental abnormalities that could compromise the school achievement of the child. Like the three and four year exam, this one is free of charge. If needed, the following examinations, care, rehabilitation, are paid for by the family and reimbursed through the social security system. This is, shortly described, a system that French families are strongly attached to. It partly bridges the gap far too often observed and possibly detrimental for the child's health and development between a perinatal period and neonatal care provided in all developed countries and the school health system.

This key period of early childhood and first socialization deserves our interest and endeavor.

Thank you.

[Prepared statement of Michel Manciaux follows:]

PREPARED STATEMENT OF MICHEL MANCIAUX, PROFESSOR OF PUBLIC HEALTH AND SOCIAL PEDIATRICS, UNIVERSITY OF NANCY, NANCY, FRANCE

EARLY SCHOOLING AND HEALTH CARE IN FRANCE

M. MANCIAUX[1]

A recent American report ("France seen as far ahead in providing child care") refered to in the New York Times (9 Nov. 1989) describes the French system of preschool programs, insisting on a child day care system largely based on early admittance to preelementary school ("école maternelle"). This deserves to be presented in a continuity starting from day-care programs for infants and young children and going on till the child, at 6 years of age, enters into the compulsory schooling, at elementary level. At various steps of this preelementary course, health care is provided by systematic checking and, if needed, by medical care in close cooperation with medical private practice. This paper intends to present the main outlines and characteristics of this continuing child day-care process, described by the report as "a blend of child care, education and health services based on free full-day preschool programs, subsidized day-care centers and licensed care in private homes for infants and toddlers."

The starting point is a complex combination of various possibilities for caring, on a day to day base, for infants and young children (under 3). The diagram illustrates this and shows that about 60 % of children under 3 are cared for at home by their mother (42 % of French women return to work after 10 to 12 weeks of postnatal paid maternity leave).

Allowances for young children, for day-care outside home, for one parent family help families cover partly the day-care expenses and refrain them from resorting to unlicensed caretakers. These allowances vary according to parent(s)' resources. Health care is provided through the MCH official system, completely free of charge and organized by the local authorities, at departmental level (the Département is a French territorial and administrative division, with an average population of 1 million). Family and various allowances distributed by Social Security for this purpose amounted, in 1987, to nearly 100 billions of French francs.

[1] Professor of Public Health and Social Pediatrics, University of Nancy, France

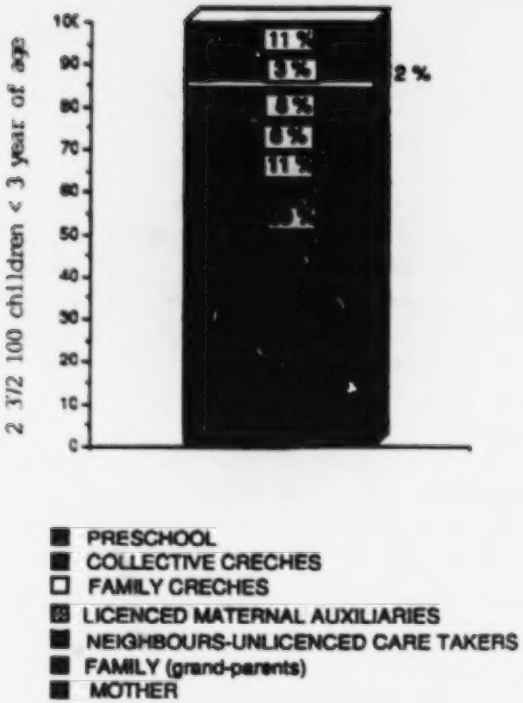

Figure 4 : Day care of children less than 3 years old.
Source : INSEE. French census 1982 ;
Ministère de l'Education, Ministère de la Solidarité-Santé 1983.

When they reach 3 years of age, most of the French children go to the so called "maternal school". About 40 % of the 2 years old attend the school, and more than 90 % of those over 3. The quoted report says : "The noncompulsory preschool programs, which serve nearly 90 % of French children three to five years old, offer language, arts, exercise, crafts and play. The system also features intensive training and fair compensation for preschool teachers and others who take care of young children, a free preventive health program for all young children, and attention to the architecture and safety of day-care centers."

Between 3 and 4, children attending school benefit from a health checkup sometimes wrongly refered to as "bilan maternel", merely because it takes place at the "maternal school". This check-up, usually done by the MCH team (doctor - child nurse - psychologist) consists of physical examination, screening for hearing, vision, psychomotor abilities, language... The MCH team discusses with the school team about the child's adaptation to school, his/her difficulties, achievements. The parents, asked to meet the MCH team, are also involved in the process : they are interwiewed on their child's health problems and informed of the results of the visit. If there is any problem requiring any sort of medical care, like immunizations to be completed or sensory defect to be confirmed by a more refined examination in order to be corrected, parents are advised to consult their family doctor or a specialist working in hospital or private practice : a letter is given to them for this physician, and the MCH team makes sure that the needed follow-up is performed, which is done, according to some evaluations, in about 80 % of the cases.

In addition, in the year before the child is admitted to elementary school, he/she is again examined with nearly the same protocol. However, this 5 years examination is under the responsibility of the school health team, who takes over the MCH team, with of course due coordination between both. This later check-up is mainly aiming at screening for any developmental abnormalities that could compromise the school achievements of the child. Like the 3-4 years exam, this one is free of charge and, if needed, the following examinations, care, rehabilitation are paid for by the family and reimbursed through the Social Security system.

This is, shortly described, a system which French families are strongly attached to. It partly bridges the gap, far too often observed and possibly detrimental for the child's health and development, between a perinatal and neonatal care provided in all developed countries and the school health system. This key period of early childhood and first socialisation deserves our interest and endeavour.

Chairman MILLER. Thank you very much. Dr. Lie.

STATEMENT OF SVERRE LIE, M.D., Ph.D., PROFESSOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY HOSPITAL, (RIKSHOSPITALET) OSLO, NORWAY

Dr. LIE. Thank you. Mr. Chairman, members of the committee, Senator Chiles, I would like first to say that I feel very honored to sit here and to be able to give you one example of the child care system in Norway.

Maybe I first should remind you about some basic facts. Norway is a large country with a small population. Actually the population density is only 12 per square kilometer, which makes it the least densely populated country in Europe, and distances are vast.

From historical times my country has been a very poor country with few natural resources as defined earlier. However, today an effective use of the tremendous amounts of energy carried by the waterfalls and the decade of exploitation of North Sea oil and gas makes Norway, perhaps, one of the most prosperous countries in Europe.

The first position for doctors was established some 350 years ago. From that very beginning medicine was socialized in the sense that doctors were paid for by the government. In the National Norwegian Health Act of 1860, this basic principle was adopted that health services should be adapted to the economic and social conditions of the local community and should, in principle, be free to all citizens.

This policy has been maintained and expounded ever since, and free access to health care is regarded today as a fundamental human right in all the Scandinavian countries.

We have an administration of health and social services in my country that functions at three levels. We have the Central Government Services, the Regional County Administration and the local government in the communes. It is the duty of the Central Administration to draw up the general health policy of the country and to evaluate and monitor how it functions. The Ministry of Social Affairs is the biggest one in the Norwegian Cabinet, spending almost one third of the budget of the public money in their budget.

The task entrusted to the county commune, which is comparable to your states, is to run hospitals and specialist and dental services. They're also required to draw up the general health policy for their county.

Now I'm coming to the main theme, which is the communes, of which we have 464. They are responsible for primary health care, both preventive and curative, and social services. It has been a general consensus in the Norwegian health debate during the last decade that there should be a commitment to decentralization, that's the only way you can get to people with the vast distances we are talking about.

This implies that important political decisions should be taken close to the people and tailored to the people's needs. The local commune, through their elected commune council are, therefore, responsible for drawing up commune health plans and to run pri-

mary health and social services, the responsibility for the care of elderly and disabled persons are likewise the responsibility of the local commune.

Preventive pediatrics is one of the main responsibilities of the local commune and I will talk a little bit about that. This work in Norway is now based on the law, which defines access to preventive pediatrics as a fundamental human right comparable to the right of education.

Before 1972, preventive pediatrics was the work of many voluntary organizations, but it was recognized by professionals, by the people, that the kind of offers at the various health stations differed vastly and that this should be a public responsibility.

The health station is in the center of this work and there is one, at least, in each community. The central person within the health station is the public health nurse, somewhat like the health visiting nurse system you heard about from England. There are also doctor examinations at the age of 6 weeks, 6 months, 12 months, 24 months and 48 months, and this is actually required by the law that this should be done.

It's certainly not obligatory to go to these stations, but the attendance rate for the community is very high. Several investigations have proven that the attendance rate in the communities in Norway is more than 95 percent. Not only immunizations, of course, but all types of preventive care are done here.

The child is seen monthly during the first year of life by the nurse who monitors growth and development and gives additional counseling on health promotion, nutrition and mental hygiene.

The running cost of these health stations is the responsibility, again, of the local community, but it's a minor expense. In one affluent community outside Oslo with 80,000 inhabitants, the total annual cost in 1988, for running these health stations was $1.5 million, compared to a total health budget of $69.2 million.

At the national level, a rough approximation would indicate that the total cost of this preventive pediatrics is about $75 million or $18 per capita per year.

Also in the schools there are preventive health services for children, which is an obligation of the community to offer, and which is also, of course, free of charge. This service is at present under discussion and will probably be reoriented towards more emphasis on risk groups and on health education, such as sexually transmitted diseases, unwanted pregnancies and so forth.

It may be difficult to prove that preventive pediatrics play a role in the rather satisfactory trends in childhood mortality and morbidity, which has been discussed earlier here. In Norway it has never been a question about the status of these health stations, they are sort of part of the culture and it would be absolutely impossible to go in and do controlled studies on the effect of them.

It's certainly something that people just like to have there. To me it is a system which is functioning very well, it is freely accessible to all and is used by all, and that, I think, is a very important aspect of preventive pediatrics.

Thank you.

[Prepared statement of Sverre Lie follows:]

PREPARED STATEMENT OF SVERRE O. LIE, M.D., PH.D., PROFESSOR, DEPARTMENT OF PEDIATRICS, UNIVERSITY HOSPITAL, (RIKSHOSPITALET) OSLO, NORWAY

CHILDREN IN THE NORWEGIAN HEALTH CARE SYSTEM

Some reflections on preventive pediatrics and selected causes of childhood mortality.

Norway is a large country (320.000 km²) with a small population (4.2 millions). The population density is only 12 people per km² (compared to 230 per km² in the United Kingdom) which makes Norway the least densely populated country on the European continent.

Norway is far up north and long and thin. The country is divided by mountains and fjords and characterized by great distances. The distance from north to south is equal to the distance from the southern border of the country to Rome. Almost 1/3 of the country lies north of the Arctic Circle, and 1/12 of the population lives here.

From historical times Norway has been a poor country with few natural resources as defined in earlier times. However, industrialization, an effective use of the tremendous amounts of energy carried by the water falls and a decade of exploitation of North Sea oil and gas makes Norway one of the most prosperous countries in Europe today.

The first position for doctors were established some 350 years ago. From the very beginning medicine was socialized in the sense that doctors were paid for by the Government simply because people could not pay themselves. In the national Norwegian Health Act of 1860 the basic principle was adopted that health services should be adapted to the economic and social conditions of the local community and should in principle be free to all citizens. This policy has been maintained and expanded ever since.

Free access to health care is regarded as a fundamental human right in the Scandinavian countries. A small fee is paid while visiting primary health care and outpatient clinics, but hospital services are otherwise free of charge for every citizen.

In 1985 the following number of health personnel were economically active in Norway (3):

Physicians	9.176
Dentists	3.702
Physiotherapists	3.701
Qualified nurses	35.552
Auxilliary nurses	36.898

(total population 4.16 million)

Inhabitants per physician has steadily decreased by time, being 884 in 1961 and 410 in 1985.

In 1988 we had 266 registered specialists in pediatrics, which gives 1 pediatrician per 3.000 children under the age of 15 years. Of these specialists 180 worked in institutions and 71 outside institutions. Private specialist practice in pediatrics is rather rare in Norway with only 66 registered in 1988. About 13-15 new specialists are now registered annually in the country.

The country has 18 pediatric departments with a total of about 800 beds (~ 1 bed per 1.000 children < 15 years of age).

ADMINISTRATION OF HEALTH AND SOCIAL SERVICES IN NORWAY TODAY

Public administration in Norway functions today at three levels: Central government services, regional county administration and local government in the communes. The country is administratively divided into 19 counties which are organized as semiindependent units with marked autonomy in selected fields. The country is further divided into 454 communes (local municipalities) of varying size (half of them having less than 5.000 inhabitants). These communes likewise enjoy a high degree of self determination in local affairs.

It is the duty of the **Central administration (State)** to draw up the general health policy of the country and to evaluate and monitor how it functions. The Ministry of Social Affairs is certainly the biggest within the norwegian cabinet spending almost 1/3 of the public money in their annual budgets. The Directorate of Health is headed by a director general and is currently divided into 5 departments. County medical officers and county governors are representing the state in the counties.

The most important task entrusted the **county communs** is to run hospitals and specialist and dental services. They are also required to draw up a general health plan for the county.

Within the local government in the **communes** the responsibilities are primary health care (preventive and curative) and social services. It has been a general consensus in the norwegian health debate during the last decade that there should be a comittment to decentralization. This implies that important political

decisions should be taken close to the people and tailored to the peoples need. The local commune through their elected commune council are responsible for drawing up commune health plans and to run primary health and social services. The responsibility for the care of elderly and disabled persons are likewise the responsibility of the local commune.

PUBLIC EXPENDITURES ON HEALTH AND SOCIAL SERVICES/SECURITIES IN NORWAY

The following table lists public expenditures on selected areas in Norway in 1972, 1980, 1986 in per cent of the Gross National Product:

Public expenditures - Norway
(in percent of Gross National Product)

	1972	1980	1986*
Total public expenditures	42.8%	45.0%	44.9%
Defence	3.3%	2.8%	3.0%
Education	6.1%	5.4%	5.3%
Health services	4.8%	6.3%	6.8%
Social security	13.7%	14.4%	15.8%

* GNP - $ 79 billions

It shows that the health service accounts for 6.8% of the gross national product and that this figure has been rather stable through the -80's.

The actual amount of money that went into the various health and social services/securities in 1987 were as follows:

Hospitals/institutions	$ 5.3 billions
Primary health care	$ 0.63 billions
Social security	$ 12.3 billions
(Gross National product	$ 89.0 billions)

Preventive & curative pediatrics - $ 0.18 billions

HEALTH SERVICES FOR CHILDREN WITHIN THE CONTEXT OF THE GENERAL NORWEGIAN HEALTH SYSTEM

Preventive pediatrics is a responsibility of the local communities. This work is now based on a law which passed Parliament in 1972 - a law which actually defines access to preventive pediatrics as a fundamental human right comparable to the right of education. Wherever in the country you live, you should have access free of charge to a well baby clinic and certain minimum services should be

provided by these clinics. For instance, the law emphasizes that there shall be an examination by a physician in the neonatal period, at 6 weeks of age, 6 months, 12 months, 24 months and 48 months of age. The wellbaby clinics are administrative run by a specialized nurse, who sees the children regularly (monthly the first year), monitors growth and development, and give additional counselling on health promotion, nutrition and mental hygiene. All the vaccinations are done here. The attendance rate for these well baby clinics is actually more than 90% and these localities are also used for health courses for parents-to-be and other preventive work and health promotion.

The running cost of these "health stations" are the responsibility of the local community, but is a minor expense. In one affluent community outside Oslo with 80.000 inhabitants the total annual cost in 1988 was $1.5 million, compared to a total health budget of $69.2 millions. At the national level a rough approximation would indicate that the total cost of this preventive pediatrics is about 75 million US$ - or 18 US$ per capita per year.

Also in the schools there are preventive health services for children which is an obligation of the community and which also is free of charge. This service is at present under discussion and will probably be reoriented towards more emphasis on risk groups and on health education, especially in relation to life style, smoking, alcohol, sexual transmitted diseases and unwanted pregnancies.

Within the general frame of the conference, it is of interest to present trends on mortality rates in norwegian children from 1971 through 1988. These rates are depicted in tables 1 through table 4.

Table 1 list the main mortality rates from selected diseases (infectious and parasitic diseases, CNS-infections, respiratory tract infections and malignant disease). It can be seen that there is a decrease in mortality from these causes in all age groups.

Table 2 show the loss of lives due to injuries, all causes. These statistics are divided by age and sex, and again it can be seen that in the years since 1956 there has been a rather dramatic reduction in mortality among children less than 14 years of age. In the age group between 15 and 19 years the mortality rate has been rather unchanged, except for females, where the mortality rate has actually increased.

Table 3 show the injury mortality by traffic accidents in the same period. In the age groups below 14 years we have seen a marked improvement while there has been an increase in the age group 15 to 19 years in both sexes.

Table 4 shows that homicide and suicide are rare events in Norway. However, the recent rise in suicide amongst teen-agers are of great concern.

It may be difficult to prove that preventive pediatrics play a role in the rather satisfactory trends which are presented in these tables. However, the fact that major

educational and health promoting activities are performed both within the well baby clinics and school health services makes it very likely that they play a major role.

TABLE 1

DISEASE MORTALITY PER 100.000 CHILDREN IN NORWAY

ANNUAL AVERAGE

	1971-75	1976-80	1981-85	1986-88
INFECTIOUS AND PARAZITIC DISEASES				
0- 4	12.9	11.3	10.1	7.3
5- 9	1.5	1.2	1.0	0.4
10-14	1.3	1.0	1.3	1.0
15-19	1.67	2.24	2.0	1.51
0-19	4.38	3.72	3.29	2.45
CNS-INFECTIONS				
0- 4	3.4	2.48	2.73	2.3
5- 9	0.6	0.3	0.35	0.4
10-14	0.6	0.6	0.31	0.34
15-19	0.67	0.67	0.3	0.3
0-19	1.35	0.97	0.84	0.7
RESP. TRACT INFECTIONS				
0- 4	16.1	11.0	10.16	6.5
5- 9	1.24	1.0	0.35	0.4
10-14	1.0	0.3	0.3	0.0
15-19	1.3	0.64	0.31	0.0
0-19	4.86	3.0	2.44	1.67
MALIGNANT DISEASE				
0- 4	6.94	5.32	5.46	4.6
5- 9	7.76	5.6	4.22	5.0
10-14	4.8	4.7	4.0	4.0
15-19	6.6	5.7	5.9	3.9
0-19	6.6	5.3	4.8	4.4

TABLE 2

INJURY MORTALITY PER 100.000 IN NORWAY BY SEX AND AGE GROUPS

ALL CAUSES

Age groups	1956-1960	1961-1965	1966-1970	1971-1975	1976-1980	1981-1985	1986-1988
TOTAL							
0- 4	40.2	38.2	39.3	30.4	20.1	12.1	10.4
5- 9	24.1	23.7	23.0	20.1	15.7	10.7	9.0
10-14	16.8	13.6	14.2	14.7	12.2	8.4	6.5
15-19	30.6	36.6	39.8	44.6	36.8	35.2	36.6
MALES							
0- 4	49.5	47.2	48.5	39.1	27.6	14.5	12.0
5- 9	36.3	34.4	32.4	28.3	21.9	14.4	13.5
10-14	26.5	20.5	20.6	20.4	16.8	12.4	9.6
15-19	52.6	62.2	64.8	74.3	57.3	54.6	56.8
FEMALES							
0- 4	30.4	28.7	29.6	21.3	12.3	9.6	8.7
5- 9	11.1	12.5	13.1	11.5	9.1	6.8	4.2
10-14	6.5	6.2	7.5	8.7	7.2	4.1	3.3
15-19	7.5	9.6	13.4	13.6	15.2	14.8	15.3

TABLE 3

INJURY MORTALITY PER 100.000 IN NORWAY BY SEX AND AGE GROUPS

TRAFFIC ACCIDENTS

Age groups	1956-1960	1961-1965	1966-1970	1971-1975	1976-1980	1981-1985	1986-1988
TOTAL							
0- 4	9.3	9.5	10.3	6.9	4.8	2.4	3.2
5- 9	8.2	10.3	12.8	9.8	6.4	5.6	4.7
10-14	4.5	4.2	6.7	7.9	6.8	4.2	3.3
15-19	11.4	16.4	22.1	28.3	23.8	24.4	25.3
MALES							
0- 4	10.1	10.8	11.4	8.5	6.8	2.7	3.0
5- 9	10.3	12.5	16.3	12.6	8.1	6.7	6.8
10-14	6.6	5.8	9.2	9.3	8.7	5.2	4.2
15-19	17.3	25.9	32.6	45.1	35.0	36.2	38.7
FEMALES							
0- 4	8.4	8.2	9.2	6.2	2.8	2.1	3.4
5- 9	6.0	7.9	9.1	6.9	4.7	4.3	2.6
10-14	2.4	2.5	4.0	6.5	4.8	3.2	2.3
15-19	5.1	6.4	11.0	10.7	12.1	12.0	11.2

TABLE 4

HOMICIDE AND SUICIDE IN NORWAY

0-19 YEARS

SUICIDE	Age groups					
	0 - 10		10 - 14		15 - 19	
	Males	Females	Males	Females	Males	Females
1986	0	0	7	0	26	5
1987	0	0	3	2	23	3
1988	0	0	5	2	37	6
Yearly average			5	1	29	5
Rate per 100.000			3.3	0.7	17.1	?.1

HOMICIDE	Age groups									
	0		1- 4		5-9		10-14		15-19	
	Males	Females	M	F	M	F	M	F	M	F
1986	0	1	2	0	2	1	1	0	4	1
1987	0	1	0	0	0	0	0	2	0	1
1988	0	0	0	0	0	0	1	0	1	1
Yearly average	0	0.7	0.7	0	0.7	0.3	0.7	0.3	1.7	1

Chairman MILLER. Thank you. Dr. Verbrugge.

STATEMENT OF HANS VERBRUGGE, M.D., D.P.H., MEDICAL OFFICER OF MATERNAL AND CHILD HEALTH CARE, DEPARTMENT OF THE CHIEF MEDICAL OFFICER OF HEALTH, RIJSWIJK, NETHERLANDS

Dr. VERBRUGGE. Mr. Chairman, ladies and gentlemen, Mr. George Miller asked me to present some innovative aspects of child health policies in our country, as these aspects have resulted in major and long-lasting improvements in child health status in the Netherlands. They even might be adaptable to the U.S. system of health care.

Although I feel very honored by this invitation, it seems somewhat presuming that I, coming from a small country like the Netherlands, should tell you now how to improve your health care system.

As you know, health status is not determined by some single factors, it's the result of a lot of determinants like the economic status of the population, first. The attainability of health care, the knowledge of people about health and health influence factor, positive or negative. Especially in preventive health care the individual attitude to make use of the available health care system, for instance prenatal care or immunizations, is very important. Last but not least, in every country the present health status and health care system has to be seen in an historical context.

I would like to present you some major characteristics of our Dutch health care system. You'll find more detailed information in the papers I presented during the conference. I gave to you a copy of them.

Our preventive health care system started in the beginning of this century, fighting against high infant mortality. Well-baby clinics were organized by pediatricians and private organizations to teach parents about adequate infant feeding, especially when breast feeding was decreasing.

Mothers were taught how to protect and even improve the health of their babies. The basic idea behind it was to be there with the poor families and mothers with children to give them support. Periodical consultations gave the opportunity to guide the growth and development of the child and offer reassurance to the parents.

In that period people also discovered that even in the prenatal period it is possible to improve the health status of the mother and her unborn child. Nowadays more than 95 percent of our pregnant mothers go for prenatal care to the family doctor, the independent working midwife and, when some pathology is suspected, to the obstetrician. Ten to 15 prenatal visits are usual.

After the Second World War, the well-baby clinics became more and more popular. The first contact is made by the district nurse during a home visit in the neonatal period. The district nurse being informed by the local birth register by a computerized prepared message like this (indicating). She takes the blood for the neonatal screening of inborn errors of metabolism.

She invites the mother to visit the well-baby clinic and more than 95 percent of the mothers do so, with an average of 10 visits

in the first 15 fifteen months. There is no obligation whatsoever, nor is there any financial stimulus.

Visiting the well-baby clinics is on a completely voluntary basis. Free access and the absence of financial or organizational barriers is considered essential. Nurses and doctors provide free advice. Well-baby clinics are situated in direct surroundings of the dwelling place.

As infant mortality nowadays has considerably dropped, our first priorities are in guidance of growth and development, early detection of abnormalities and improvement of health and health conditions. Another major item of this is to combine these well-baby clinics with the immunization program, as most of the DTP-Polio and MMR immunizations are given in the well-baby clinics.

This is the explanation of our high coverage percentage in our immunization system. Ninety-four percent of our babies receive four injections of DTP-Polio in the first 15 months. The MMR coverage is also 94 percent at this age. There is no legal obligation to take part in our immunization system, participation is on a voluntary basis and free of charge.

This leads me to a very important system, our financing of this preventive health care system. In my paper, "Youth Health Care in the Netherlands," you can find a short description of our insurance system. The most important fact is that preventive health care is fully paid by a compulsory national insurance law covering everyone living in the Netherlands.

Access for mother and babies is free of charge and the total costs are about $100 million, that's about $125 per child per year. You can compare it to one day of hospital care.

Besides that the cost of the immunization program is $70 million per year, it means $13 per injection, again, free of charge for the patient. By that we reach an immunization rate of 95 percent, as said, at the age of 15 months. These costs are a part of our total cost of 8.3 percent of the gross national product.

At the end of this statement I shall try to come to a prudent recommendation, considering that all children below the age of five, and that's about five to six percent of your total population, form a group with well-described health risks. It should be possible to realize free access for the health care system, curative as well as preventive.

It should be possible to create nationwide compulsory insurance to cover the cost in this respect. The leading theme in this process of changing has to be more solidarity and less solidarity, respectively less individuality of the whole nation, and that is not simple. In the Netherlands we learned a lot in the Second World War.

After the Second World War our second class public health care became MCH for all. The ultimate goal is free access for all children to the health system, curative as well as preventive. This population approach will be very helpful in prenatal care, MCH care and school health care. The free access to the health care system pre- and postnatal can be considered as an investment, resulting in lower medical costs and an improved health condition of America's children, being tomorrow's adults.

Thank you.

[Prepared statement of Hans Verbrugge follows:]

PREPARED STATEMENT OF HANS VERBRUGGE, M.D., D.P.H., MEDICAL OFFICER OF MATERNAL AND CHILD HEALTH CARE, DEPARTMENT OF THE CHIEF MEDICAL OFFICER OF HEALTH, RIJSWIJK, NETHERLANDS

Ladies and Gentlemen,

Mr. George Miller, your chairman, asked me to present some innovative aspects of child health policy, as these aspects have resulted in major and long lasting improvements in child health status in the Netherlands. They even might be adaptable to the U.S. system of health care. Although I feel very honoured by this invitation, it seems somewhat presuming that I, coming from a small country like the Netherlands, should tell you now how to improve your health care system.

As you know, health status is not determined by some single factors. It is the result of a lot of determinants like the economic status of the population, the attainability of health care, the knowledge of the people about health and health influencing factors, positive or negative. Especially in the preventive health care the individual attitude to make use of the available health care system, (e.g. prenatal care or immunisations) is very important. And last but not least in every country the present health status and health care system have to be seen in a historical context.

I would like to present you some major characteristics of our Dutch health care system. You will find more detailed information in the papers I presented in the conference.

Our preventive health care system started in the beginning of this century, fighting against a high infant mortality. Well-baby clinics where organized by pediatricians and private organizations to teach parents about adequate infant feeding especially when breastfeeding was decreasing. Mothers were taught how to protect and even improve the individual health of their babies.

Periodical consultations gave the opportunity to guide the growth and development of the child and offer reassurance to the parents. In that period people also discovered that even in the prenatal period it is possible to improve the health status of the mother and her unborn child. Nowadays more than 95% of our pregnant mothers go for prenatal care to the family doctor, the midwife and (when some pathology is suspected) to the obstetrician. Ten to fifteen prenatal visits are usual.

After the second world war the well-baby clinics became more and more popular. The first contact is made by the district nurse during a home visit in the neonatal period, the district nurse being informed by the local birth register. She invites the mother to visit the well-baby clinic, and more than 95% of the mothers do so, with an average of 10 visits in the first 15 months. There is no obligation whatsoever, nor is there any financial stimulus.

Visiting the well-baby clinics is on a completely voluntarily basis. Free access and the absence of financial or organizational barriers is considered essential. Nurses and doctors provide free advise.
Well-baby clinics are situated in the direct surrounding in the dwelling-place.
As infant mortality nowadays has considerably dropped, our first priorities are guidance of growth and development, early detection of abnormalities and improvement of the health and the health conditions.

Another major item is to combine these well-baby clinics with the immunization programme, as most of the DTP-Polio and MMR immunizations are given in the well-baby clinics. That is the explanation of the high coverage percentage of our immunization programme. 94% Of our babies receive 4 injections DTP-Polio in the first 15 months. The MMR coverage is also 94% at this age.

There is no legal obligation to take part in our immunization programme. Participation is on a voluntarily basis and free of charge.

This leads me to a very important item, the financing of our preventive health care system.
In my paper Youth Health Care in the Netherlands you can find a short description of our insurance system. The most important fact is that the preventive health care is fully paid by a compulsary national insurance law, covering everyone living in the Netherlands.
Access for mothers and babies is free of charge and the total costs are about 100 million US-$ (about 125 dollars per child per year). Besides that the costs of the immunization programme are 17 million dollars per year, it means 13 dollars per injection, again free of charge for the parents.

At the end of this statement I shall try to come to a prudent recommendation.

Considering that all children below the age of 5 form a group with well described health risks, it should be possible to realise free access to the health care system (curative care as well as preventive care). It should also be possible to create a compulsary insurance to cover the costs in this respect.

The ultimate goal is free access for all children to the health care system (curative care as well as preventive health care). This population approach will be very helpfull in the prenatal care, the Maternal and Child Health Care and the School Health Care.

Free access to the health care system (pre- and postnatal) can be considered as an investment, resulting in lower medical costs and an improved health condition of America's children, being tomorrow's adults.

Chairman MILLER. Thank you. Dr. Miller.

STATEMENT OF C. ARDEN MILLER, M.D., PROFESSOR OF MATERNAL AND CHILD HEALTH, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

Dr. MILLER. Mr. Chairman, Senator Chiles, members of the committee, thank you for the privilege of meeting with you. I am especially grateful for having met and conversed with these gentlemen and Ms. Goodwin for the past 2 days.

Two years ago a group at the University of North Carolina conducted a study of 10 Western European countries that had better infant mortality rates than the United States. The purpose of that study was to determine exactly what kinds of supports and services those countries render in order to achieve their favorable records. That report has been made available to you. We have followed it with a continuing study of those same countries, four of the countries represented here are in that study, in order to determine what kinds of services and supports are available to children, and what is the status of children's health.

In my written testimony, I have prepared a summary of the findings of that report. The full report will be available to you within a month or two. My comments today will not attempt to incorporate the full written testimony, but instead to highlight certain features that may be of special interest to you.

A fair question asks why study other countries. Can we really learn anything from them? We all know that services and supports grow out of unique political, social and economic traditions. Among the countries discussed today there are great differences in their health care financing, and in their provider systems. They are not cookie cutter programs, and yet there are certain consistent themes that prevail. It is those themes that I would like to emphasize. I think it important to point out that even though there are profound differences among these countries, and even though each works out its own systems of care, there are a limited number of strategies by which young families and children can be helped. It seems to me important to identify those strategies and to build on them.

Before dealing with those themes, I would like to record a few circumstances that cause us to be concerned about the status of children's health in this country. A lot of attention has been directed to our high infant mortality rate; not so much attention has been given to the fact that our mortality rates are higher for children in every age group through 19 years than in most of the countries under study.

In the age group one to four, the chances of death in the United States are 1.3 to 2 times greater than in the Western European countries that have reported to you. The two points of greatest excess death in this country are in the one to four age group, and in the 15 to 19. Very different causes relate to those two groups.

Death in the 15 to 19 year age group is largely associated with violence, much of it with handguns. Handgun deaths in the other countries studied are a rare event; they are a common event here. In the age group one to four, interestingly enough, excess deaths

also relate primarily to injury. Injury, for the most part, is related to inadequacies of supervision and oversight of children, and involvement in routine preventive health care.

Dr. Harvey emphasized the high proportion of our preschool age children who are not immunized. The importance to be attached to that fact is the high proportion of children who are not involved in routine well-child preventive care. If one regards immunization rates as an indicator of children who are involved in such care, assumptions are justified that about one-third to half of our preschool age children are not participating in well-child medical supervision.

Beyond that, good data are available, much of it reported by this committee, on the high proportion of our children who have no regular source of medical care. Or, if they do have a regular source of medical care, it is apt to be in an emergency room or an outpatient department that has no continuing responsibility for children and often does not provide them with adequate preventive services.

These circumstances are unknown in any of the countries reporting to you today. No children in these countries need ever ask where they will get care or who will pay for it. They are all automatically enrolled, ordinarily in two systems of care, one to assure routine screening, immunization, well-child services, and another for consultation and curative care.

Poverty rates deserve emphasis. They are the subject of intensive recent international comparison. It would not be hard to get medical experts to come together around the belief that reduction in poverty rates would do more to improve children's health than any other intervention.

These studies used the United States' definition of poverty, apply it to the European countries, and determined what proportions of families with children lived in poverty using parity purchasing powers of income. We have twice as many children in poverty as any of the countries represented at this hearing. The poverty is more severe in the United States. Every country has mechanisms for alleviating poverty. Our mechanisms are just half as successful as the European countries.

The means for alleviating poverty are more generous for single-parent families than they are for other families. Unlike Japan, some countries, Norway is one, Netherlands another, do have a high proportion of single-parent families. The benefits available to those families are more generous than to conventional families.

Within the past few days, emphasis has developed that in each of the study countries the routine, readily available programs of care for chronic illness and handicapping conditions are more consistently available than in this country.

Finally, that as far as adolescent pregnancy, abortion and child bearing are concerned, our rates are much higher than theirs, in spite of the fact that available evidence shows that the age of onset of sexual activity is about the same in all of these countries.

What are some of the themes that seem to be common for improving child health? The first is consistent, equitable, uniform access to health care without means testing and without payment at the time services are delivered. That circumstance is true of all the study countries. Circumstances are much different in the United States. In North Carolina the process of means testing

takes much longer than a thorough examination. We work to keep people out of our systems of health care; other countries work to incorporate everyone in their systems of care.

The second point that I want to emphasize is that we tend to regard in our health care systems that our client is an individual and we design our payment and insurance mechanisms around an individual payment process. These countries do that, but they also regard that community as a client, and they provide financing in order to make sure that community services and resources are adequate to meet the needs that cannot be met on a one to one basis. An example will serve again from my own state. Since the expansion of Medicaid eligibility and benefits, we have had a 25 percent increase in the number of pregnant women seeking prenatal care in public clinics. The waiting time for that care has expanded anywhere from 4 to 6 weeks. We do a thorough job of educating women that they ought to get into prenatal care early and then delay by as much as a month before they can have their first appointment. The clinics are not able to meet the demand and without up front funding, without improving facilities and staff, I don't think additional case loads are possible. Fee for service reimbursement funding is not the way public agencies are financed. They cannot expand their services on the basis of anticipated fee for service earnings sometime in the future.

Finally, in all of the study countries there are thorough, well-established tracking systems to follow children and to make sure that no one is overlooked. The tracking systems are different from one country to another. It may be by home visiting programs as Ms. Goodwin described; it may be by computerized systems, or it may be by enrolling at the time of birth every infant on a panel for a physician's care. But no one is overlooked.

Again circumstances are different in this country, where we know a lot about pregnant women and infants at the time of delivery, we know a lot about them at the time the children enter school, and we know very little about them in between. There are vast numbers of children who are overlooked and involved in none of the appropriate and necessary services.

The study countries consistently take a broad view of the supports and services that are necessary to assure good health. That approach speaks to the importance of the family and the integrity of the family as a means for assuring the health and well-being of children.

The study countries protect family care through paid leaves from employment, through assured return to jobs after leaves and through consistent non-means tested children's allowances to all families to enable parents to do the important work of staying home and raising their own children if they wish to.

In the United States we have created a circumstance by which two incomes are required to support many families. Having created that circumstance, we have a higher proportion of mothers in the labor force than any of the study countries. U.S. mothers in the labor force are more apt to be full-time. Having created these conditions we do much less than any of the the other countries to provide child care.

Child care provisions are available at little or no cost in all of the countries, ordinarily for 80 to 100 percent of all 3 and 4 year olds. In this country we have about 29 percent of children in subsidized child care, and meet the need for only about 20 percent of those who would be qualified under Headstart.

The price we pay for these neglects is enormous. A study in North Carolina a few years ago concerned children ages one to four who suffered death from burns, one of the common causes of death in that age group. The study revealed that 67 percent of the children at time of death were supervised by care givers who were disabled, bedridden, inattentive, inebriated or absent. Under those circumstances of child care, the chances of death from burning were seven times greater than children who were under adequate supervision.

Let me close by saying that I admire so much the work of this select committee. Your support for children is well-known and enthusiastically applauded. I want to remind you that we still have enormous needs to meet and that we still have no well established national priority to serve the needs of our children. I am one, along with others, disappointed by the fact that when we begin formulating objectives for the Nation for the year 2000, there is no priority for children; there is no priority for families. The supposition presumes, that if we take care of everyone, we will take care of children and families, too. But we don't.

Thank you very much.

[Prepared statement of C. Arden Miller follows:]

PREPARED STATEMENT OF C. ARDEN MILLER, M.D., PROFESSOR OF MATERNAL AND CHILD HEALTH, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, CHAPEL HILL, NC

The following information and interpretations derive from a study in progress dealing with preventive health services for children in ten Western European countries. The study is based in the Department of Maternal and Child Health, School of Public Health, University of North Carolina, Chapel Hill, North Carolina. The project director is Dr. Bret Williams, Research Associate in that department.

Verbal testimony will attempt to incorporate additional information and perspectives from presentations at the "Conference on Cross-National Comparisons of Child Health", Washington, DC, March 17 - 19, 1990.

C. Arden Miller, M.D.

Concerns about U.S. excess infant mortality feature international comparisons which demonstrate adverse trends for the U.S. when measured against the progress in other industrialized democracies. Contributing factors favorable to other countries are thought to include:

- reduced unintended pregnancies;
- consistent participation of pregnant women in early and continuous prenatal care that is available without financial barriers;
- linkage of maternity care to comprehensive social and financial benefits that enable pregnant women and new mothers to protect their own well-being and to nurture their infants;
- careful monitoring of pregnant women and newborn infants for social or medical problems that require special attention, and easy access to the indicated supports and services. Home Visitors are a conspicuous feature of the monitoring system in a number of the countries (Miller 1987).

New attention focuses on the sad circumstance that many unfavorable indicators of child health in the U.S. extend well beyond the first year of life.

- Excess Mortality. Death rates for U.S. children are higher than for their Western European counterparts at all age groups through age 19 -- higher by a factor of 1.3 to 2.0 for children 1 - 4 years of age (NCHS, 1989). As with infant mortality, survival rates for children are improving in all industrialized nations, but more rapidly in Europe than in the U.S. Excess U.S. mortality among children is almost entirely attributable to deaths from injury. The leading natural causes of children's deaths --

congenital defects, malignancies, and respiratory infections -- occur at about the same rates among all the leading industrial nations. U.S. deaths from drowning, burns, handguns, and misadventure with automobiles, exceed those in Western Europe by a substantial margin (NCHS, 1989). The high homicide rate among children in the Western world is almost a uniquely U.S. phenomenon (Rockett et al., 1989). It is the leading cause of death from injury in the first year of life (Waller et al., 1989).

Excess U.S. deaths among children are concentrated in two age groups: 1 - 4 and 15 - 19 years of age. In the U.S. children in their late teens are the only age group for whom deaths have increased rather than diminished since 1970 (Fingerhut & Kleinman, 1989a). Three out of four teen-age deaths are due to homicide, largely by firearms; these deaths have increased by 31 percent since 1986 (Fingerhut & Kleinman, 1989b). In 1986 there were more than 1000 firearm-related homicides among U.S. males aged 15 - 19 years. In the same year there were 25 such deaths in Canada, Japan, England and Wales, Sweden, West Germany, and France -- all together (Fingerhut & Kleinman, 1989b).

Many deaths among 1 - 4 year-olds are associated with inadequate vigilance and supervision by care givers. The leading causes of death are burns and automobile-related injuries. An analysis of all fatal house fires in North Carolina during 1988 is instructive. Sixty-five percent of child fatalities from burns were associated with a care giver who was absent, inattentive, inebriated, or bed-ridden. A child under five years of age was seven times more likely to die in a fire under these circumstances than a child in a house fire where a non-compromised child attendant was present (Guglemann, 1989).

More than half of automobile-related deaths among 1 - 4 year-olds occur to pedestrians and cyclists -- often in driveways and parking lots -- rather than to occupants (NCHS, 1989). Pedestrian death rates are highest among one-year-old children (Baker & Waller, 1989). Children as automobile occupants are especially vulnerable in alcohol-related crashes. During a three-year period in North Carolina more than half the deaths in alcohol-related crashes occurred among children as passengers in cars with an alcohol-compromised driver (Margolis et al., 1986).

- Abuse and Neglect. Abuse and neglect of U.S. children are well-documented problems that have increased during the 1980's beyond what can be attributed to reporting artifact (Select Committee, 1987). The same problems are known to exist in all of the study countries with frequencies generally considered to be much less than in the U.S. Indirect evidence supports those assumptions -- homicide rates and other measures of social dysfunction suggest that we are a more violent society than Western Europe. There is every reason to believe that violence impacts disproportionately on children -- but data from Europe are lacking. Child abuse is not generally reported to national authorities, and surveys have not generally been done.
- Participation in Preventive Health Care. Two measures stand out to separate U.S. children from their European counterparts with respect to well-child medical care. The first is identification of a regular source of care, and the second is the immunization rate for preschool-aged children.

  1. A Regular Source of Care. Seven to twelve percent of U.S. children have no regular source of medical care (poor, 12 percent; not poor, 7 percent). Another 16 to 34 percent identify as a regular source an institutional place, such as a clinic or

hospital emergency room (urban poor, 34 percent; not urban, non-poor, 6 percent; Kasper, 1987). Available data do not enable accurate disaggregation of the institutional places according to sponsorship or the scope of services rendered. Emergency rooms would seldom render comprehensive well-child care that includes developmental evaluations, immunizations, and anticipatory guidance. Clinics might be centers of comprehensive community-based care of an exemplary nature, or they might feature walk-in single-purpose visits for fragmented and symptomatic management. Estimates on the proportion of U.S. children with absent or uncertain regular services of medical care range between 12 and 46 percent, depending on economic status and place of residence (Kasper, 1987). Use of institutional places rather than physicians' offices appears to be increasing, and to be only partially offset by Medicaid eligibility. For poor children, Medicaid coverage was associated with only 4 percent greater likelihood of seeing a physician than being without Medicaid (Kasper, 1987).

Charney emphasizes that the U.S. differs from most other nations in attempting to provide preventive health care through a personal health care system featuring office-based private physician practitioners (Charney, 1986). In most other countries, routine preventive health care for children is rendered by public health nurses and other personnel in settings (home, school, or community clinic) different from the settings in which illness care is featured. The U.S. effort to integrate preventive health care into primary private practice settings appears to work well for most children in families who are well integrated into middle-class institutional patterns. The system may not work well for poor children, or those who present problems

derive from complex social dysfunction. In general, children's physicians do not spend much time on preventive care (Charney, 1986). One study revealed that anticipatory guidance consumed only 8.4 percent of the average visit: 97 seconds for patients younger than five months, and 7 seconds for 13 to 18 year-olds (Reisinger & Bires, 1980). Even when efforts were made to intensify office-based anticipatory guidance and to focus it on injury prevention, the results were disappointing (Dershewitz & Williamson, 1977).

On the other hand, at least two well-controlled studies demonstrate that home visiting is associated with subsequent reduction in early childhood injuries (Olds et al., 1986; Larson, 1980). In spite of these findings, home visiting to pregnant women, new mothers, and their infants are rarities in the U.S. (Conyer, 1985).

Circumstances concerning usual sources of health care are very different in European countries. No child or parent need ask where care will be rendered or how it will be paid for. From one to three readily identified provider systems enroll every child in care and involve little if any out-of-pocket expenditures. In many of the countries (e.g. Denmark, Ireland, Netherlands, Norway, Switzerland, United Kingdom, and Belgium) post-natal home visiting by a health visitor or other provider is routine for every new mother and infant. One of the tasks of the home visitor is to assure that any indicated follow-up medical attentions for the infant are attended to, and that the infant is linked to a continuing source of medical care.

In several of the countries, continuing care consists of enrolling the infant on the panel of patients for which the family's physician, usually a general practitioner, is responsible. Pediatric care is usually hospital based for purposes of consultation.

In other countries, the infant can be taken for follow-up care to any physician of the parent's choice under a national financing system that assures universal and equitable access. Very often visits to these providers would be made only at the time of illness because yet a different system of care routinely follows infants and young children for developmental check-ups, screening, anticipatory guidance, and immunizations. These clinic systems are extensive in Spain, Ireland, U.K., Netherlands, French-speaking Belgium, and Norway. In West Germany, France, and Switzerland these community children's clinics are available only in locales of special need, as for large concentrations of foreign workers' families. The neighborhood clinics may be organized and run at the community level under central government mandate and financing (e.g. Norway), or run under government oversight and financing but operated by quasi-public agencies (Netherlands and French-speaking Belgium), or operate as extensions of a school health service reaching downward into the preschool age group. The exceedingly high proportion of European 3 and 4 year-olds who are enrolled in government-operated preschools (three-fourths or more in France, West Germany, Netherlands, U.K., Belgium, and Spain) assures that these children have had physical examinations, developmental check-ups, and routine immunizations at an early age.

2. Immunization Rates. Immunization rates of young children are useful proxy indicators of participation in well-child care. The utility is not perfect because group immunization of children is sometimes done without including any of the other components of preventive care. That practice is not usual in advanced nations except occasionally for subpopulations threatened by epidemic. Among the nations in this

study we believe that completed immunizations for children under three years of age are a useful reflection of participation in some defined sequence of continuing care that is more comprehensive than the immunization itself.

Accurate data on the immunization rates of U.S. children are elusive. National surveys conducted by the Centers for Disease Control were discontinued after 1984, but hopefully will be resumed in the near future. Nearly all states require evidence of immunization at the time of school entry, so the level of protection for school-aged children is quite high. The most vulnerable age groups are preschoolers and young adults, both of whom have experienced recent outbreaks of measles.

Preschoolers who are enrolled in licensed care such as Headstart are nearly all immunized, but they represent a small proportion of the total cohort under three years, by which age all schedules of well-child care recommend completion of primary immunizations. The best and most recent data on immunization rates for U.S. children between 1 and 4 years of age derive from household interviews of a sample of the civilian non-institutionalized population between 1983-85. Data of two sorts derive from that survey: respondents who rely on recall, and those who have a written record which they consult (NCHS, 1989). Those with a written record (35 percent of white respondents, and 19 percent of others) report, as would be expected, higher immunization rates. Only those children who had received at least one immunization would have a written record, and it probably would be located most commonly among families who make frequent use of it.

U.S. immunization rates for very young children are much lower than in the European countries. The European data indicate 90 percent or better immunization in

most of the countries, and better than 80 percent in all of them. The U.S. data reveal that only half to two-thirds are completely immunized, the rates being especially low among minority and inner-city populations, and tending to get worse in the most recent years for which data are available (Select Committee, 1989). Most of the European countries in the study maintain computerized data systems to monitor immunizations; trends in recent years have been toward more complete immunization (Bytchenko, 1988). To the extent that immunization of young children serves as a proxy measure for participation in well-child care, conclusions are justified that one-third to one half of young U.S. children are being missed.

- Social Supports

1. Benefits Associated with Childbearing. The substantial supports, services, and financial benefits associated with childbearing in the ten European countries were previously reviewed and compared with circumstances in the U.S. (Miller, 1987). Additional reliable data are available on tax benefits and income transfers for the purpose of alleviating poverty among households with children (Smeeding & Torrey, 1988; Smeeding, Torrey, & Rein, 1988). A report from the Commission of the European Communities provides extensive data on child care (day care and preschools) among the European nations (Moss, 1988).

2. Alleviation of Poverty. A popular ethic holds that adversity has a toughening effect that enhances initiative and cultivates resourcefulness. Data point in the other direction with relation to children born in poverty. Starfield has written extensively on the subject. She wrote: "Poor children are more likely to become ill, more likely to suffer adverse consequences from illness, and more likely to die than

other children" (Starfield, 1982). "The effect of poverty is independent of other social and biologic factors. An analysis of maternal education, socioeconomic level, and childhood deaths revealed a major socioeconomic effect on the mortality of children and teenagers" (Mare, 1982).

Child health experts the world over might well come together behind the utopian ideal that elimination of poverty would do more to improve children's health than any other objective to be hoped for. The ideal is more vigorously pursued in Western Europe than in the U.S. Many analysts have reviewed the sad circumstance that in the U.S. children have become the predominate age group living in poverty; that the proportion increased dramatically early in the 1980's, affecting nearly one in four young children; and that circumstances for children did not improve in the late 1980's as other indicators of national economic well-being were said to recover.

Smeeding and Torrey made ingenious use of the Luxembourg Income Studies to compare the extent to which different nations alleviate poverty among households with children (Smeeding & Torrey, 1988; Smeeding, Torrey, & Rein, 1988). For purposes of comparison Smeeding and Torrey used the U.S. government's standard of poverty, adjusting the dollar amount of the U.S. poverty line by conversion to other currencies and using standard purchasing-power parities. The years of reference are 1979-81. The U.S. had more poor children and more poor families with children than any other country in the study. Inclusion of non-cash income benefits did not improve the relative condition of U.S. children. Non-cash benefits are consistently more generous in the other countries. The U.S. absolute poverty rate for families with children (17.1 % in 1979-81) was more than twice as great as the rate among other

countries in the health study (West Germany, Norway, Switzerland, United Kingdom; average, 7.9 %).

The poverty of U.S. children was more severe than in other countries. Three and a half times more U.S. children were in the lowest 75 percentile of poverty (9.8 %) than children in other study countries (West Germany, Norway, Switzerland, and the United Kingdom; average rate, 2.7 %). The differentials were not eliminated by disaggregating data on the races. The poverty rate of white children in the U.S. was higher than the rate for all children in the other European countries.

Some family structures are more vulnerable to poverty than others. The U.S. poverty rate for children in one-parent families has received much attention. Other countries with a high proportion of single-parent families protect them from such high poverty rates through special benefit programs (e.g. Norway and Switzerland).

All countries alleviate poverty to some degree in households with children, either by means of tax or transfer benefits; none of the countries has entirely eliminated poverty among households with children. Overall, the U.S. programs reduce the pre-transfer poverty population by 17 percent; programs in other countries reduce the number of families in poverty by twice as much.

U.S. programs differ from European approaches in two important respects. U.S. pre-transfer/post-tax programs tend to be means-tested, whereas European programs are more universal, relying on social insurance based on employment history and on children's allowances across all socioeconomic groups. Medicare for the elderly is the major social insurance program in the U.S. that is not means tested. As a consequence, the relative per capita social spending for the elderly is more

generous in the U.S. than in Europe. When the per capita social spending for children is held constant at 100 in all countries, the U.S. spends more per capita on the elderly than any other country (O'Higgins, 1988).

The second major difference between U.S. and European programs is the participation rate of poor families in programs for which they are eligible. In other countries efforts are made for the programs to be *inclusive* -- reaching all eligible families. In the U.S., through budgeting caps, enrollment barriers, and state-based eligibility limitations, the programs have the effect of being *exclusive* -- designed to keep people out. Fewer than half of poor families in the U.S. participate in such poverty-alleviating programs as WIC, Food Stamps, AFDC, Medicaid, and Headstart.

Data during the 1980s suggest that circumstances have worsened for poor children. Between 1977 and 1980 the poorest fifth of U.S. families experienced reduced income by 11.8 percent, while the richest fifth gained 30.3 percent in family income (Greenstein, 1990).

2. Preschool Child Care. Vigilance over the safety and supervision of young children in the U.S. is a matter of growing concern. The contributory factors are especially great in the U.S. because of the large proportion of parents working outside the home and the expense and inadequacy of day care arrangements. The mothers of more than half of preschool-age children in the U.S. are employed outside the home, 80 percent of them full time. Fifteen percent of all U.S. households with children have a preschool child in a lone-parent family; 59 percent of those parents are employed outside the home. These circumstances require provision for child care far

in excess of the European countries studied, yet our access to child care services is far less than in Europe.

We have a smaller proportion of four-year-old children in preschools than any of the European countries studied despite a higher proportion of mothers of preschool children working outside the home. Even among our most affluent families, preschool participation rates (53 percent) are lower than in Europe. Among poor families, only 29 percent of U.S. four-year-olds are in preschools.

Enriched and qualified preschools are known to be safe (Chang et al., 1989) and for poverty-level children participation is known to be associated with improved health and socialization into young adulthood (Lazar & Darlington, 1982; Weikart, 1989). Headstart is the most extensive public preschool program for poverty-level children in the U.S. Twenty-two percent of three-to-four-year-olds qualify, but the programs enroll only twenty percent of those who are eligible (Weikart, 1989).

Kamerman emphasizes that neither maternal employment nor out-of-home child care is a condition that is in itself harmful to children (Kamerman, 1984). What may be exceedingly harmful are makeshift arrangements for child care. Qualified infant and toddler care for children under three years is both rare and expensive in the U.S. For three-to-five-year-olds care in preschools or licensed centers predominates, with about 25 percent of children cared for in homes or family day care which may or may not be registered (Kahn & Kamerman, 1987). For infants and toddlers care in homes predominates, often without registration or regulations for safety. Stipek and McCroskey estimate that 40 percent of U.S. preschool children are in family day care arrangements, 70 percent of which are unlicensed (Stipek & McCroskey, 1989). The

average annual cost is a formidable $3,000, representing ten percent of the average annual household income (Stipek & McCroskey, 1989).

Favorable child care circumstances are more characteristic of Western Europe than the U.S. (Moss, 1989). European three-to-five-year-olds are typically cared for in government-regulated and -subsidized day care centers or preschools at little if any cost to their parents (Tietze & Ulferman, 1989). The supply of such placements is generally sufficient to meet the need. Day care for infants and children 0 - 3 years of age is also regulated and subsidized in Europe, but not always in a quantity sufficient to meet the demand, resulting in a "gray market" of uncertified day care in some countries and of waiting lists in others (e.g. Denmark, where the employment rate of women is especially high). Fees for certified and public day care are determined on a sliding scale that seldom exceeds 20 - 35 percent of actual cost. Many centers are open from 6 o'clock in the morning until 7 or 8 o'clock at night; in some areas the centers are open 24 hours a day in order to accommodate the children of parents who work at night (Moss, 1989).

Every nation's institutions and human services grow out of their respective unique traditions. None can be readily transposed to another. Yet there a a limited set of strategies known to benefit childbearing women, infants, children, and young families. Many indicators point to the failure of U.S. institutions to protect these vulnerable populations with supports and services of known effectiveness. Our traditions move toward the neglect of children; their well-being suffers in comparison with those in other advanced nations. We face the risk of a growing Third World quality that characterizes the status of U.S. children's health.

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Corrective measures will not be easy. Much attention focuses on reforms in the financing of medical care and tax benefits for day care. These reforms are legitimate and urgent. They are not apt to be sufficient without concurrent progress in moving children and young families out of the blight of poverty. Growing wealth among the richest sector of the population is not yielding trickle-down benefits for the improved health of U.S. children.

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Chairman MILLER. Thank you very much, Dr. Miller, for your testimony.

Let me just say to each of you on the panel that this is more than an abstract discussion. There is, in fact, a serious discussion taking place in the Congress currently about how we start to provide a comprehensive, universal program for pregnant women and children, some programs for young children and some children up to the age of majority.

Later this afternoon I will be testifying in front of Congressman Stark's committee, the Ways and Means Committee, that is looking at doing this through the Medicare system. Congressman Waxman is considering such a proposal through the Medicaid system. So what you're telling us here today is also being factored into the current legislative processes.

Thank you for your testimony. I'm encouraged by it because there are so many models that we can look at. This isn't a problem that we are going to solve by taking one item and increasing the health of our children. I am embarrassed by it because we have failed in 200 years to embrace such a policy.

Birt, let me ask you, if I might start with you, what seems to come across is interesting in a sense that, as Dr. Miller pointed out, this is not a cookie cutter operation. Other countries haven't arrived at the same financing mechanisms, the same delivery systems, the same accessibility, but it seems to me that there is a dramatic philosophical difference.

That is, in each of the programs that has been discussed here there is a notion that you are entitled to health care, whereas in our system it would seem just the opposite. It's there if you can afford it. If you can't afford it, you're not entitled to it.

Then, of course, we construct a delivery system for poor people in this country. As I think Dr. Miller pointed out, I'm not sure the members of this Committee can fill out some of the applications to become eligible. They've now taken on a booklet form. Rather than being proud of a system that would deliver health care to the Royal Family, we seemed to have designed a system that would be embarrassed if a Rockefeller accidentally or intentionally took their child to this program and got free care.

How serious is that philosophical difference, if I'm correct, in terms of our ability to design this system?

Dr. HARVEY. I agree with you. It's there, and it presents huge problems for us. Take a teenage mother who has her baby and wants to get that child on Medicaid. Can you picture a 16-year-old having the documentation, being able to go in, and filling out those kind of forms? It's a tremendous barrier, and I think we do construct barriers to access to care.

The trouble is, even beyond that, it's a two-tier system. It's an unequal system, a terribly unequal system. Even Medicaid in itself is inequitable. A child doesn't pick one state to live in in contrast to another. Even within the same state, you can find under Medicaid that a 3-year-old will be covered for pneumonia while a 5-year-old sibling will not be eligible for care.

If you forget Medicaid and look at how we treat children based on disease. We have established the most elaborate program for children who have kidney disease. If you have end stage renal dis-

ease, no matter where you live, what your income, you can have a kidney transplant.

If you happen to be a child that has end stage lung disease or liver disease, you darned well better hope you have mighty good insurance or that you're in a state where Medicaid will pick this up, but your chances are like roulette. It's based on the organ that happens to be involved—kidney versus lung or liver.

In our crippled children's programs, under Title V, some states will cover a child with leukemia, but other states won't. The child doesn't choose what state to be born in. He doesn't have a right to choose his or her parents. We ought to have a level playing field for all children.

We ought to give all children as good a chance at equity as we can. Obviously, we can't do it perfectly, because every family is different, but at least we can give them a chance for equal health care. I agree with you; that's what we don't have in this Nation and what we do need.

Chairman MILLER. Dr. Pless, since the program is relatively new in Canada, obviously the continued fear seems to be here that if we're to make a program universal, the cost will simply explode on us and will be out of proportion to the value returned, if you will, in improved health care.

Yet when I look at the per capita cost, obviously in Canada, it's lower. We have more members of Congress going to Canada to look at health care now that probably your growth industry is entertaining members of Congress looking at health care.

How is that achieved? You've been in both systems and yet our health care costs are just continuing to escalate almost more rapidly than any other cost in the economy. Yet yours aren't and there's relatively free access to the system.

Dr. PLESS. I'm glad you asked, because I was going to ask for an opportunity to add to what was just said so eloquently, to remind you of precisely that component.

The actual administration of health care costs in Canada—there are three parts to the answer. One has to do with the fact that it's a great deal less expensive to administer our system of health insurance than it is to administer the Medicare and Medicaid components alone. The difference has been estimated by good health economists to be in the neighborhood of about $6 per capita.

That is to say, our entire system can be administered for $21 per capita. It costs you $26 per capita to administer just the Medicare and Medicaid components alone. So the savings in administration are enormous, absolutely enormous, that's one thing.

The second thing is, and this will not make me popular with my physician colleagues——

Chairman MILLER. Let me ask you just for clarification, for my own clarification, when you talk about administrative costs we get into discussions here between private and public programs and transactional costs. Transactional costs, that's what we would consider just the processing of the forms?

Dr. PLESS. The whole smear.

Chairman MILLER. When you talk about administrative, you're talking about the whole administration?

Dr. PLESS. Everything from the cost of filling out and processing those forms to insuring that the information contained in them is correct and the delivery of the checks, and what not.

The second part, of course, is that we really can control costs more effectively. This is not to suggest that we haven't had an increase in health care costs, and it has alarmed many Canadians, including the economists. But the fact is that the government can say to physicians when it sits down and negotiates with physicians, what they're billing charges will be, and they cannot exceed them.

One talks about the unhappiness of Canadian physicians, but we have not had the massive migration south of the border, as some people fancy. In fact, it has been recently pointed out that the migration in the other direction equalizes any losses. So there are a fair number of physicians coming to Canada because they feel more comfortable in a system such as ours.

Of course, the third component, and perhaps the most important component, is the ability to control possible costs. Although we have a fairly lavish system in Canada, probably far more lavish than many of us feel it needs to be, it nonetheless can be controlled far more effectively, and has been controlled far more effectively, than has yours.

Chairman MILLER. Thank you. Let me ask you, Mr. Manciaux if I just might, and then I want to give other members a chance to respond. Let me ask you, you talk in your testimony about the follow-up treatment for 80 percent of the preschoolers that have been screened. How do you achieve that level?

Mr. MANCIAUX. I mean that, if the screening by the MCH team or the school health team demonstrates any abnormality to be confirmed and to be cured by private physicians, specialists or by hospital units. The coordination is assured between the MCH team or the school health team and doctors in private or public practice. Eighty percent of those children found by the screening test having, for example, a hearing deficiency are effectively and sometimes efficiently followed by the private and the public sector outside of school. It is only a control of the efficacy of the system.

Chairman MILLER. Let me ask you, is that by referral from the MCH teams, or is it at the parent's initiative that they then take the information given to them by the screening team and follow up?

Mr. MANCIAUX. It is both, as a matter of fact, because parents are asked, of course, to follow up what has been found on their child. At the same time a letter is sent by the MCH team to the physician or to the hospital department chosen by the parents and the coordination is insured by this letter.

One point more, 3 months after, for example, the MCH team asks the schoolteacher or the parents whether the follow-up has been insured, and the answer is yes in 80 percent of the cases.

Since I have the floor I would like, if you permit me, sir, to say a few words concerning new aspects in the French health policy which are linked with the recent act on decentralization, giving more competence and responsibilities to the departments.

After two centuries of very high centralism, this decentralization created some problems. In some departments these territorial units

now in charge of MCH and other responsibilities in the field of health, some disparities appeared.

For example, some departments did better and more for children than others. At the beginning of this decentralization the central power did not want to interfere in order to respect the autonomy and the freedom of the local level, but after having found these discrepancies between departments, sometimes, for example, an increase in the rate of premature deliveries, the central power decided to intervene and to pass an act which has been effectively passed last December, in order to fix a minimum level of care that should be insured in all departments.

So it is a combination of freedom and autonomy at the departmental level, but with some level which is guaranteed by the intervention of the central power. Thank you.

Chairman MILLER. Thank you. Mr. Holloway.

Mr. HOLLOWAY. Thank you, Mr. Chairman. Let me start out by asking a question of the countries represented here. What are the policies of your countries as far as immigration is concerned? What is the number of immigrants you have coming in that you have to care for through health programs, through child care programs? As you know, we're a country of many races, our country is a melting pot of the world, and we have a tremendous problem associated with that.

I would just like to know whether you have the same type of problems we have, or to the degree that we have them.

Chairman MILLER. Whoever would like to respond.

Ms. GOODWIN. If I can just say that in England there are some parts of some of our inner cities which are almost 100 percent immigrant population, for example, Indian, Pakistani, Bangladeshi families, whose mothers were born in those countries and the children were born in my own country. We don't collect any indicators on a racial basis, we collect our data on social class.

Mr. HOLLOWAY. May I go a little further to ask, what is your current policy toward allowing immigration, and how strict are you on allowing immigrants to come into the your countries?

Ms. GOODWIN. We have restricted immigration over the last 10 to 15 years, to the point where the only people who are probably coming in from the countries, Afro-Caribbean, Asian countries, are those who already have links or family in England.

Mr. HOLLOWAY. If you do catch illegal immigrants, what happens to them?

Ms. GOODWIN. Well, they get deported eventually after the due process of appeal. We're expecting, of course, a large wave in from Hong Kong sometime in the next 10 years. How we deal with that as a country is going to be interesting.

Mr. HOLLOWAY. In a follow-up to this I'd like to hear if you would agree we have a tremendous problem to address here that you do not. We have a problem of immigrants continuing to come in, particularly from Caribbean countries, from Mexico, as well as from many other countries.

I wish you would, if you have any light to shed on the subject, propose solutions to our problems with immigration. We cannot make the long range forecast that you can in your country. We cannot say we have 40 million people today and we're going to be

addressing 40 million people in the years to come. We can't do that and I'd like to hear if you have any input on this problem.

Ms. GOODWIN. I'm not quite sure what you're asking us, Mr. Holloway. In my country we have at the moment about five percent ethnic minority populations, and that number, in our case, could well increase unpredictably in the future with foreign policy changes.

The way we, I think, approach meeting the health needs of such populations is at local level by looking at the populations, the problems they present and introducing modifications of our editions to our existing programs, for example, the one I've been talking to you about, which is specifically targeted to those populations and which respond to their needs.

I can't answer the broader policy issue, I'm afraid.

Mr. HOLLOWAY. You would agree that we have a much greater problem with immigration than your country does?

Ms. GOODWIN. You're telling me you do, I accept that you do. I don't think it means that you have insurmountable difficulties. We have similar sorts of problems and we have our own and have found our own solutions and I think you can learn from some of the things that we've done as well. I don't think it means that our countries cannot in anyway be compared to yours.

We also have minorities, significant minorities who have much higher levels of morbidity and mortality, and we have to tackle them in our way as you do.

Mr. HOLLOWAY. Five percent of your population being immigrants is a very small percentage compared to ours, very small.

Ms. GOODWIN. That is only Asian and Afro-Caribbean. We have other groups. We have very large numbers of homeless families, we have gypsy and traveling families, and we have some others, as you do here, a very large proportion of what I call an under class, people living in poverty.

One in three of children in Britain live in or on the margins of poverty, and I consider those to be as much a group requiring special attention as immigrants, because immigrants are poor people generally speaking. It is the poverty which is the problem, not the race.

Chairman MILLER. Mr. Wagner, I see you chomping at the bit.

Mr. WAGNER. I just want to make a quick comment.

Chairman MILLER. I don't think I can stop you, so go ahead. [Laughter.]

Mr. WAGNER. I work for the World Health Organization and one of the member states that I'm responsible for is Israel. So I know quite a bit about their child health care system and so forth. I'm sure you know, Mr. Holloway, that their immigrant population far exceeds the United States.

At the same time their child health indicators are essentially as good as the United States. One of the things that they have had for many, many, many years is universal access to child health care in Israel. In talking to the Israeli authorities, they have struggled and struggled with these massive immigrations of people from all over the world continuing today.

It's a terrible struggle for them to try to get the health care, because the immigrants are often in very bad levels of health. You're

absolutely right, it's a serious problem. Somehow or another, through their national health system, they have been able to manage it.

Mr. HOLLOWAY. Next I would just like to say that we know there's a correlation between the infant mortality rate of single-parent families, and we know from the latest national health survey of family growth that more teenagers are more sexually active than in 1982, and that children are becoming sexually active at younger ages.

In view of this, I'd ask Dr. Miller, what is the probability today of a 14-year-old girl who is sexually active becoming pregnant before she finishes high school, and then what is the possibility of her becoming pregnant before she finishes college?

Dr. MILLER. I don't have those data in front of me. I know that they are readily available. I do know that the likelihood is much greater in this country than in any of those that you have heard from, because in those countries teenagers are efficient contraceptors in distinction to this country where they are not.

Mr. HOLLOWAY. I guess I would say that education can solve this problem and not the government. I think that we have a problem that we have to address and I hope that we can address it in ways that, through television and other means, will convince these young people that the way they are going is not the way to go.

You say on page 3 that you indicate that excessive U.S. deaths among children are concentrated in two age groups, 1 to 4 and 15 to 19. Between 1970 and 1986, these death rates for children ages 1 to 4 declined by 38 percent to 52 per 100,000. To help us put this excessive rate into perspective, can you tell us the rates for these ages in other countries?

Dr. MILLER. That information is readily available. I don't have it in front of me, but I can cite you the figure that in the one to four age group, our rate is about 1.3 to 2 times as high as it is in the Western European countries you have heard from.

Mr. HOLLOWAY. I'll close by saying it seems clear that most of the poor health outcomes can be traced back to single-parent families. Unmarried mothers are more than three times as likely as married mothers to obtain late or no prenatal care.

Can the Federal Government really reverse this trend toward out-of-wedlock births and increases in the divorce rate, which are the root of many of these problems?

Dr. MILLER. I think it would be instructive to hear how some of the other Federal Governments, Netherlands and Norway have addressed that question, because they have done it with great effect.

Mr. HOLLOWAY. Can any of the other panelists respond to this question?

Dr. VERBRUGGE. Are you talking about the adolescent pregnancy?

Mr. HOLLOWAY. Well, is the Federal Government really the answer to this?

Dr. VERBRUGGE. I don't know if the government can do so, but in our country we have a very low rate of abortion and pregnancies in young girls. You know there is a big study from the Gutmann Institute and what it says is that the starting period of sexual activity between boys and girls are quite the same.

What can be the difference that the girls become pregnant in your country and become not pregnant in our country? I think there is more——

Mr. CHILES. I missed that, did you say the starting rates of sexual activity?

Dr. VERBRUGGE. The starting age.

Mr. CHILES. The starting age of——

Dr. VERBRUGGE. Of sexual activity between boys and girls in the different countries are nearly the same.

Mr. CHILES. Nearly the same?

Dr. VERBRUGGE. Nearly the same. So there's not a shift of later in Holland and earlier in America. What I think is that there's more knowledge about the hazards that can be in sexual activity. What can be the source of that? My personal opinion is that in our country we are talking more with children about sex, sexual education and the hazards of sex.

It's more open discussion than what I hear here in your country. I don't know your country so well that I can say how to change it, but I think it is necessary to have very early, from the age two, three and four, on their levels, to talk about sexual differences between boys and girls and what it means later on and when there is this second child coming at the age of 4 you can talk and discuss about it, mother, father and the child.

I think these things are not going on here in your country. When a girl is 10, 11, 12 years old, when menarche is—they have to intensify that discussion.

The availability of contraceptives is quite not a problem. The access to the family doctor is the problem for the girl, maybe for the boys there is freedom to buy condoms, but that's not the first choice. The first choice of contraceptives in our country for girls is the pill.

The pill you can get with your family doctor, and when you don't like to go to your family doctor who is known by the family. When your mother and father don't like it that you have sex, then you can go to the Rutgerstichting (nush), what we call, it's a network of consultation bureaus where special tariffs are and where they can get some education on using it, not using it and the dangers.

Mr. HOLLOWAY. Well is the sexual activity at these ages acceptable? Is there anything——

Dr. VERBRUGGE. You can discuss about it, it's not forbidden. It's better to talk about it than to hide it. That's my personal opinion.

Mr. CHILES. Is there any parental consent required to go to these facilities to get birth control?

Dr. VERBRUGGE. Yes. A quarter of the population who don't like to go to their own family doctor goes to the Rutgerstichting (nush). Oh, no, they have not. It's not necessary.

Mr. HOLLOWAY. So they don't have to have parental consent?

Dr. VERBRUGGE. No. No. No.

Dr. PLESS. Mr. Chairman, may I add just an observation to this? I don't disagree with your quoting Arden Miller's paper, I'm in fundamental agreement with it. But my other hat is that of an epidemiologist. I have looked at the relationship between teenage pregnancy and health outcomes.

For a long while it was thought the answer was as simple as you've just described it, Mr. Holloway, but I'm convinced from the data that it's not merely the fact that teenagers are having more and more children or that those children are at high risk simply because their parents are teenagers.

To my mind there are two other factors that are probably far more important than just the biological age of the parent. One is the underlying X factor, the factor that is held in common between the poor child health outcomes and the fact that these girls are becoming pregnant at an early age. By and large that's poverty again.

So we're back to that phenomenon. The question is not what can we do to reduce those pregnancies, but what can we do to insure that once those pregnancies occur the infants of these mothers are cared for properly.

I think that's where I come back to, and many of us represented here would argue the same, that under the systems of health care that we have in our countries, those children would be well cared for and, hence, the mortality rates would be far different for those children than they would be in the United States.

Mr. HOLLOWAY. One final question, Dr. Miller, and that is in regards to your statement, and I'll try not to misquote, if I do you can let me know.

You led us to believe that we do not have the commercial day care in this country that we should, but you also stated that in many of the informal type child care centers there was severe abuse. I was led to believe that and I think statistics show that there is more abuse in commercial child care centers than there are in situations where grandparents, family members, or relatives are caring for children.

In your statement, you led us to believe that commercial child care is better. I question that and I personally feel that in care by religious providers parents, relatives, and grandparents, the figures show that there is less abuse there than there is in commercial child care centers.

Dr. MILLER. The thrust of my intent was to indicate that licensed child care is a more satisfactory and safer place than the makeshift arrangements that many parents are obliged to provide for their children.

Mr. HOLLOWAY. I would disagree with you there.

Chairman MILLER. Yield to the chairman for a second. Just a point of clarification, I think in your testimony when you were talking about accidents and death to young children you talked about care givers falling asleep, drinking, not being attentive. I assume there you're talking about all care givers, not in an organized setting or in a formal day care arrangement for pay?

Dr. MILLER. Thank you for that clarification. That's true.

Chairman MILLER. Is that right?

Dr. MILLER. Yes.

Chairman MILLER. So you're talking about a parent not being attentive, a sibling or——

Dr. MILLER. A neighbor, a housekeeper.

Chairman MILLER. Does that also include formalized child care arrangements?

Dr. MILLER. I know of no circumstances that I described that were in licensed day care arrangements.

Mr. HOLLOWAY. I have no further questions, Mr. Chairman.

Chairman MILLER. On this question of the health outcomes of teen pregnancies, let me just ask you, and if you can verify it, fine. If not, we'll have to have the staff go to work on this because I see there's some concern here.

First of all teenage pregnancies are a rather small percentage of pregnancies that contribute to infant mortality; is that not correct?

Dr. MILLER. That is true. Furthermore, I think the newest data would show that we probably have misinterpreted and exaggerated the importance of the marital state for teenage pregnancies. There is evidence to suggest, particularly among black females who become pregnant, that their babies' birth weights and survival rates are better if the mothers are unmarried than if they are married. The presumption is that if pregnant teenagers stay home with their own families, they are better off than if they leave home and marry an unemployed teenager.

Chairman MILLER. Let me also ask you when we look at pregnancy outcomes, isn't the greater determinant whether or not you had access to health care early rather than your marital status or even your age or almost anything else? As I remember the statistics when we were looking at them, if you had good health care, you had a pretty good chance of a good outcome of that pregnancy.

Dr. MILLER. That is true, but the term, good health care, needs some definition. It doesn't mean brief visits in and out of an office for a urine check and blood pressure, it means comprehensive care that provides counseling, education, enrollment in WIC programs and all of the supports and services that we associate with comprehensive care.

Under those circumstances early prenatal care does make a difference. The truth is that in the absence of that kind of comprehensive care, prenatal visits are not a strong determinant of pregnancy outcome.

Chairman MILLER. It's interesting that Mr. Holloway would draw the conclusion that government can't solve this problem after hearing from witnesses that a number of governments have apparently solved this problem. Perhaps it's more revolutionary than I think, because maybe we could then change the government if this government can't solve the problem. It's an interesting notion.

Let me ask you, Dr. Verbrugge, the setting that you describe here, you are not talking about everybody going to a physician's office, as I understand. Again, in the other countries you're talking about locally organized clinics and schools; is that correct? You're sort of going where the people are?

Dr. VERBRUGGE. Only a very small part of the girls. Most go to their own family doctor.

Chairman MILLER. They do go to their doctor, in fact?

Dr. VERBRUGGE. Yes, maybe together with the mother. When she doesn't like, when there is some quarrel about it at home, then she can go to the Rutgerstichting (nush).

Chairman MILLER. You're talking in terms of birth control?

Dr. VERBRUGGE. Yes.

Chairman MILLER. I'm talking now just in the general population for your children for preventative care. You're going where, to a physician's office? Are you going to community clinics?

Dr. VERBRUGGE. No, to the Cross Society of Public Health Clinics for MCH. There's our consultation bureaus, as we call them, where the district nurse has already visited the parents just after birth, as I said she got a message that there's a child born from the birth registry and then she goes there at day seven to take some blood from the child for PKU and CHT (congenital hypothyreoidism), the neonatal screening for inborn errors.

There she makes an appointment, they ask will you visit our bureaus, our Consultation Bureaus, our MCH or do you not, and in most the answer is yes. Then she can make an appointment in the next week, in the next 14 days or something like that.

When she finds a child at risk or a mother at risk in that situation in the time between, she can come back for a home visit, but that's not necessary in most cases, it's only seldom. Then, from time to time, they make an appointment and at the third month the injection, the first DTP-Polio injection is given during this consultation. So not in private practice, but in the public health system.

So the combination between the public health MCH care and the public health immunization program, I think that's one of the good items in our MCH care. That's why I have our high coverage rate. You missed some costs of the private immunization in pediatric or in GP practices.

Dr. LIE. I would just like to emphasize that in my country the situation is rather like in the Netherlands. To come back to your first question to the president of the Academy, I think that it should be stressed that this service is the responsibility of the public administration. It's not the responsibility of the individual. It's up to the local government to provide these services and to see that it is available for all.

To Mr. Holloway's comment about the immigration population, I would just like to say that, of course, it is also the responsibility of the local government to provide equal services for those who come to the country. In Oslo that is not a small group, it's 10 percent of the newborns are now belonging to another culture.

Chairman MILLER. Yes?

Dr. PLESS. I don't wish to enter into a debate with my colleagues but I think it's terribly important that the Committee understand that although those systems that are unusual and essentially public health oriented-based systems in the Netherlands and Norway are very impressive, I would argue that the fundamental difference that accounts for the rates that we are embarrassed by in the United States, as opposed to those which we're proud of in our countries, is not some fundamental reorganizational point within the system.

The common factor is health insurance. The reason I say that is because our rates are comparable to theirs but our system is almost entirely similar to yours in terms of the delivery of antenatal care. Most of it is done in private offices by physicians who are reimbursed by the state, if you will.

Our public health sector is not as powerful as it used to be. I regret that, and I would prefer that it be different and I envy what they have. My point is that the essential ingredient that accounts for most of the variance is the method of payment and the fact that people have no deterrent from seeking care, whether that care be in the public health sector or in private offices.

Chairman MILLER. Dr. Harvey.

Dr. HARVEY. I think in general that Dr. Pless is right, but I think we have other barriers besides just the financial barrier to access to care, immunizations being another one. Some areas just don't have available private facilities. There are geographic barriers, there are cultural barriers, and there are a number of other barriers to access to care.

We must take care of that financial one because that's the cornerstone, really. Then, after that, we still have to make sure that there are facilities available, that mothers are educated to get their children's immunizations, that transportation is made available, and that facilities to take care of their other children are available. So we need to address the financial, but we can't forget the other barriers.

Chairman MILLER. Ms. Goodwin, let me ask you a question. Professor Manciaux talked about follow-up there. To what extent do you—what are you able to tell us about follow-up from the home visits when trouble is diagnosed with the child? Are you able to look at the levels at which a parent will then go ahead and get——

Ms. GOODWIN. I can't tell you what the levels are, but it would be very unusual indeed for a problem to have been uncovered during the course of home visiting or the family's attendance at a child health clinic. It would be highly unusual for that not to be followed up.

I mean, everyone is followed up. If the people don't come for appointments, the health visitor goes home and reminds them, arranges transport and all the other things. It would be highly unusual for anything uncovered within the system not to be pursued until the conclusion of treatment of investigation.

Chairman MILLER. Let me ask you, maybe you have anecdotal evidence, but would that be the case of the visitor having to find it on one visit, she comes back and it's still not taken care of so she dogs the person a little bit to get it done? I assume the best about maternal instincts here and you want your child to be healthy, so you would go to the doctor if somebody said your child is ill.

I was just wondering because we have some cases, even where we have a halfway decent screening program, we never know what happens after that.

Ms. GOODWIN. It's my experience that it's usually not on the family's side that there are obstacles to prevent follow-up and resolution. It's usually that there are intervening obstacles such as lack of transport, inadequate alternative arrangements for the care of other children.

The family may not have enough money to put money aside to take the bus to come to the clinic to have the baby's hearing tested again. On the other side, any obstacles are quite often the responsibility of the service in that we hold clinics during working hours, and tend not to have things in the evenings and weekends.

We are not very good at ensuring that where there are, for example, significant ethnic minority populations, that we have facilities that are user friendly for those populations. We have very few health visitors, for example, who are black in areas where there are very high levels of black people. There are half a dozen, one or two black health visitors, for example, in such areas.

So we have problems of making our services more accessible to people, and we have practical obstacles presented by social and environmental factors. It's my experience that very, very few families, indeed, deliberately neglect not following up health problems that have been uncovered.

In fact, quite often it's the families themselves that have uncovered the problem before anyone made them come to a check up clinic. They know, quite often, and they have trouble convincing us sometimes that there is something wrong, because we think we're the experts, whereas, of course, they are the people who, given the opportunity and support are the expert caretakers of their children.

We often fail to respect them for that, particularly when they're very young and single. My experience, once again, along with others is very few very young mothers are not good mothers. They have problems, usually from poverty, but they are no less motivated to love and care for their children than are much older men and women.

Chairman MILLER. Mr. Chiles.

Mr. CHILES. Thank you, Mr. Chairman. We see in our country a tremendous disparity between the rates of infant mortality, and I think other health problems as well, between our minority populations and our white population as such. You have both in England, Canada and in France a minority population to an extent, do you have that disparity of rates the same?

Ms. GOODWIN. Yes, we do. A very great disparity in some respects. For example, our Bangladeshi babies and mothers have a higher rate of congenital abnormality, have much, much worse perinatal mortality rates than the others. We're not really quite sure what's going on there, except that some of the other immigrant groups don't demonstrate the same increased morbidity and mortality.

Once again, I think the consensus suggests that it's a function of socioeconomic difference rather than racial or ethnic, because the Bangladeshi groups in our country are really right at the bottom of the heap in terms of income.

Mr. CHILES. They're at the bottom. How about in France?

Mr. MANCIAUX. About the same. For example, the gradient between the infant mortality rate of French people as an average and the ethnic minorities is 1.7, and it is exactly the same between the well-to-do French families and the poorest ones. It's not an ethnic problem—again, it's a problem of living conditions, which are the same for ethnic minorities and for poor French people.

Mr. CHILES. So in your traditional French family the rate is about the same between the rich and the poor, but it's not the same between your ethnic, is that what you're saying or not?

Mr. MANCIAUX. No. I wanted to say that between French families of the upper social class and French families of the lower social

class, the difference in infant mortality rate is 1.7, and you find exactly the same difference between the average infant mortality rate of the French population and the average mortality rate of the ethnic minority.

Mr. CHILES. I see. So it is the rich-poor?

Mr. MANCIAUX. The social belonging, so to speak.

Mr. CHILES. In Canada?

Dr. PLESS. There's no question, from having looked at the data across countries, that the social class gradients are present everywhere. I think the important point to be learned is twofold: one is that the gradients diminish over time. I can speak best about Canada because we have, in effect, this natural experiment where, as recently as 20 years ago, we introduced health insurance. So we have rates from before and after.

We see that the discrepancies between upper and lower social class families have diminished over that period of time. It's a softening effect that the insurance system has.

Second, I would agree entirely with what I think both of my colleagues are saying, that it is far more the social class difference, regardless of racial group, that accounts for the phenomenon that we're looking at, rather than anything that is unique to a particular immigrant or racial subgroup.

Mr. CHILES. That's true in the Netherlands?

Dr. VERBRUGGE. We have about a five percent immigrant population, most of them are Turkish, Moroccan and Surinam people but the latter are talking Dutch so that's less a problem. The Turkish and Moroccan people have very high birth rates, three times the Dutch birth rate. When they come into our country there are differences in the mortality and differences in caretaking, differences in immunization rates.

What we've seen is that after one or two years, a period of, let's say, acclimatization the differences are decreasing. When a man is speaking Dutch and one or two years later the woman is speaking Dutch, then the differences slow down.

Dr. LIE. I can just support what other people have said, that after a while the differences which could be there in the beginning are fading out. I think one interesting fact which you have seen also in Norway, which is so homogeneous and where it's said that very few have too much and very few have too little, it is a definite trend towards a higher infant mortality rate in the poor or the less educated white mothers in Norway.

So we find that when the numbers are big enough it is quite clear that there is a trend also in my country that if you are poor then your outcome is worse.

Chairman MILLER. Could we just have a——

Mr. WAGNER. Can I make a quick comment?

Chairman MILLER. Get that man a seat at the table. [Laughter.]

Mr. WAGNER. A few minutes ago Barry Pless said that he felt that the single most important factor common to all these countries is they have national health insurance. I would say there are two factors that are equally important, and he's named one.

The other factor has to do with what we're talking about now, and the fact that you can go to any country in the world and you see that the infant mortality is higher when you have poverty.

Both minority members of your Committee made a very important point, because they were talking, for example, about single mothers and families.

They are absolutely right that what happens in the family on a day to day basis is very, very important in the health of that baby. The second factor that all of these countries have in common is a commitment to help families, all families.

So, for example, the United States is the only industrialized country in the world that doesn't have paid maternity leave. Every one of these countries has a child allotment, I'm talking cash, not coupons, given to families with babies to help them with their children.

If it is a single parent family, that allotment is doubled. So the point is that the second very, very basic thing that all these other countries are doing, is they are providing for the families.

Chairman MILLER. Dr. Miller, let me ask you if you might comment on Senator Chiles's question, because I think it's important. I think it also suggests how we look at the system when we think about redesigning it or changing it. If you have a strong-held belief that somehow bad health care is intrinsic to the black community or to the Haitian community or to the Hispanic community, I would suggest then it's pretty hard to figure out how to design a system.

If, in fact, these statistics jump out at us, as I think I've seen on this Committee, based on economics more than anything else, then that system can be redesigned. If this is something that we believe—I don't know, I spent a lot of time in Central America and wealthy Salvadorans have really healthy kids and real healthy families, and real poor Salvadorans have real unhealthy poor kids and unhealthy families.

I don't know whether your study would help us here, because it's kind of fundamental to your notion about what can be done or not be done.

Dr. MILLER. I don't know that our study enlightens this issue very much, but I have examined with care data from a number of other studies about the difference in pregnancy outcomes for minorities. If one corrects for every known contributor, alcohol consumption, cigarette smoking, education, socioeconomic level, most of that difference disappears. There is a small residual gap that we don't understand and can't quite explain, but it accounts for such a small portion that it's of fascination to our statisticians and shouldn't be of much concern to our policymakers.

I think the best prospects for improving outcomes in populations who have multiple risks of low education, low socioeconomic level and high risk behavior, appear to be organized community programs that are designed specifically to address these issues. Experience in North Carolina, South Carolina and Eastern Kentucky now, is that such high-risk individuals attending community-based comprehensive care programs do much better than those who are enrolled for care in private physician's offices. That does not mean that physicians in their offices fail to give excellent medical care. It means that patients there don't have access to WIC, home visiting, transport and the full array of services that these people need. I agree with the statement that was made earlier that the prevailing

system of care in this country for pregnant women and for others is, and I suspect will continue to be, care in physician's offices. I think that for geographic, cultural and other reasons alternatives simply have to be made available for high risk populations. Those alternatives in many parts of the country are vastly improved public health services systems and community clinics.

Mr. CHILES. Dr. Miller, I just wanted to ask you, we were talking about—you were talking about pregnant teenagers and the kind of care that they're getting.

Do not the figures also pretty strongly show that where they are getting medical services across the board, in other words counseling and everything that goes with that, that there is a great decrease in the repeat and frequency of the space between the pregnancies?

Dr. MILLER. Yes, I think that is true. I think it is also true that although there are 1,000 good reasons why teenagers would be well advised to delay their childbearing, they are very efficient at it. We probably have exaggerated the contribution that teenagers make to our statistics on poor pregnancy outcomes. The data that I see suggest, again correcting for all other factors, that poor outcomes may pertain to those under 16 years of age. But for those over 16 years of age, again correcting for all available circumstances, the outcomes are just as good as for older women. Again, that doesn't mean that teenagers aren't well advised for social, economic, and educational reasons to delay their childbearing. It does mean if given adequate services and supports, they don't have to have unhealthy babies.

Mr. CHILES. I know they're very effective at it, my concern is if we can reduce a lot of figures in my state would show that if there is a pregnancy at 14 or 15, there will be three children by the time that mother reaches 18. If we can reduce those pregnancies to half, we start getting on top of our problem very quickly, we make it where we can deal with it.

Dr. MILLER. I understand the issue that you are posing, and I quite agree it is possible to intervene and reduce repeat pregnancies.

Chairman MILLER. We are, by federal statute, going to set an age at which you can engage in sexual activity, but that will be debated in another panel. [Laughter.]

It's interesting to note because I think we have exaggerated much about teenage pregnancy. In our family history some of the Millers age 16 and 14 started out from St. Louis and walked to San Francisco, and their father came with them because he didn't think they were too young to be married, he just thought they were too young to walk across the country with the Indians. I'm sure that we thought they were good moral people.

I'm just concerned to the extent that we have—one of the interesting things brought out in this panel is that from the onset of this Committee, and certainly before, over the last decade this Congress has been in turmoil over teenage pregnancy, sexual activity, sex education, and that whole gamut of issues. Yet what we're learning from these comparisons is with relatively the same age of onset, and I guess the same rate of activity by young people, the outcomes don't have to be as they are in the United States, either

with a high abortion rate or with a high unhealthy birth rate among those infants and those women.

So maybe we have provided some tools here to policymakers that rail about this subject, who can, if they would like to, do something about it, which may be a different situation, but I think that's very helpful.

Let me ask you, Dr. Harvey, we've been talking about the outcomes, the statistical differences in various categories with respect to children and the successes and failures. Underlying all of this is really the cost of these systems in comparable cost per child per capita, percentage of GNP. Is there any way to look at the real premium we seem to be paying for this sort of segregated health care system that we have?

We put people into categories and we seem to try to provide a system of health care for the extended unemployed, for the poor, for the elderly, for people with medical insurance, and for people that don't have it. Now we're going to mandate to employers that they have to provide benefits for certain levels. We keep segregating this into finer and finer systems, all of which have different criterion and transactional costs and outcomes and benefits. It starts to look like we're moving in almost the opposite direction of what's been suggested, that we can get some economic benefits and better health care.

I'm almost of the belief that this notion of mandating employers now, which I've supported over the years, is almost the absence of a thoughtful plan. We're just going to make this somebody else's problem because we either don't want to do it or don't know what to do. So in the meantime, that will hold off 40 million uninsured people in this country, who are coming to get us.

Dr. HARVEY. Thank you for giving me the opportunity to comment since the Academy has been developing a proposal to provide access to care for all children and all pregnant women in this country. We do know that with an employer-based program, for small employers the cost of overhead of insurance is terribly high.

We do know that when it's for large groups, such as Chrysler or IBM, the overhead for insurance is considerably less. Therefore, we are developing a plan to provide insurance coverage for all children; the employers would either pick up a package of comprehensive benefits for children or pay an employer-based payroll tax.

The employer-based payroll tax of 3.17 percent provides a very comprehensive package for all children——

Chairman MILLER. All children, ages?

Dr. HARVEY. Through age 21 and all pregnant women from the onset of their pregnancy for care that may not even be related directly to the pregnancy itself. In other words, a woman who has diabetes needs care for diabetes. A woman who has sinusitis needs care for it because it can have an indirect impact on the pregnancy.

The administrative overhead for insurance in large plans where many children would come under the employer payroll tax rather than a direct benefit from the employer is less than 10 percent; it's about eight or nine percent. That is a way of cost saving.

I'm sure you're all well aware, certainly Senator Chiles is of the $3.34 that the IOM showed as cost savings from prenatal care. We

know that immunizations have saved many dollars. One dollar spent on immunization saves $10 in care, no less the tragedy of those children who are permanently damaged or who die.

So there is cost saving in preventive care. There is cost saving in large scale insurance. We do need to address all the health needs of all the children. It's in our national interest.

You and I are going to be dependent upon wage earners for our social security. So not only is it morally right, it's in our self-interest.

Chairman MILLER. At the rate we're stealing the social security funds, it won't make any difference. [Laughter.]

Dr. HARVEY. I'll let you address that.

Chairman MILLER. That's another issue, too. Thank you very much for your testimony. I think this has been very, very helpful.

I think that sometimes it's all too easy for politicians to jump at comparisons between our country and other countries. But I think in this instance when we look behind these figures now, as we've started to this morning, we also see that clearly there are some models that we can be considering in terms of changing some of those statistical comparisons and the health outcomes of our children.

So I really appreciate you taking your time to give us your expertise. The record will remain open for a period of two weeks. If there is something that you would like to submit to the record based upon the interchange that you heard today, I would certainly appreciate you doing that, because that would be helpful to the committee. Mr. Wagner, that also goes for you, you would have the same opportunity.

Thank you very much, the Committee stands adjourned. Again, my thanks to Senator Chiles for helping to arrange this hearing and the conference.

[Whereupon, at 11:45 a.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF MARSDEN WAGNER, REGIONAL OFFICER, MATERNAL AND CHILD HEALTH, WORLD HEALTH ORGANIZATION, COPENHAGEN, DENMARK

Cross-National Comparisons of Child Health: The U.S. Dilemma

Marsden Wagner

The main reason why the U.S. is so far behind the other highly industrialized countries in infant mortality and other measures of child health is not because of marked differences in child health services, but because of differences in the portion of children in the population living in poverty, and the kind of care and support given to families and their children. European countries do have more comprehensive child health services with much better access and we can learn from their experience, but we must bear in mind that the contribution of these health services to child health is marginal. There can be no doubt that the single most important factor in the lower levels of child health in the U.S. is poverty. There is a higher percentage of children in the U.S. living in poverty than in the other highly industrialized countries. An article in Scienc in 1988 "Poor children in Rich Countries" showed this and also showed that child poverty rates in the U.S. increased from 16% in 1979 to 20% in 1987.

That living in poverty adversely affects child health has been known at least since 1662 when John Graunt published "The Bills of Mortality." Since that time, massive research data has accumulated

showing the fundamental role poverty plays in levels of child health. We don't need more research on this. Living in unstable, fragmented, highly stressed families in bad housing, going hungry, gun fights in the streets, schools with poor education, which are so dangerous the children are afraid to go to school: this is what leads to poor child health, not missing a well child visit.

If you look carefully at the specific child health issues to be discussed at this conference, you will find poverty involved in every case. Immunization levels are associated with poverty. Post neonatal mortality rates are well known to be a sensitive indicator of socioeconomic status. Unintentional injuries in young children are associated with poor housing, no day care for working single mothers and other signs of poverty. An important factor in hearing impairment is low birthweight which is associated with poverty. Unwanted adolescent pregnancy in the U.S. is associated with poverty. So while we struggle to improve the health services for these specific problems, and the overall child health services they represent, we will meet with little improvement in child health if we don't do something simultaneously about the poverty and its social consequences which underlie it all.

So how do we attack child poverty and its consequent poor child health? Let's get real. There is no quick fix. A piece of health service for poor kids here, another piece there, won't do it. A long range plan is needed. And here we can learn from other

countries. There are important fundamental differences in the way other countries combat child poverty--differences in the way they care for children. My own experience, first as a child health specialist in the U.S. for 15 years and then as a child health specialist in Europe for 15 years, has forced me into changing several paradigms in order to understand child care programs in other countries.

The first paradigm which must be challenged is: us versus them, the haves and have nots. In the U.S., means tests are performed, target groups identified and then services thrown at them. In other industrialized countries, generally, the services and benefits for families are for all families--what is good for a poor child is good for all children. Instead of distributing special programs to the poor, the focus is on redistributing resources among all the people.

The next paradigm in need of shifting is the notion that child health is dependent on child health services. In every country in the world, including the most highly industrialized, the contribution of health services to the overall level of child health is marginal. Much more important, for example, is the quality of care provided in the home, the physical environment, parenting, etc. This is why it is so important to examine the support which other countries give to families with children.

A third paradigm in need of a shift is the notion that health

care can be treated separately, as if it existed in a vacuum. There is a wide spectrum of care for children including care in families, welfare services, such as paid parental leaves after childbirth and child allotments, day care, schools, and, yes, health care; they must all work closely together and support each other rather than competing for resources. Other countries have shown that a coordinated package of care for children can improve their standard of living, which will lead directly to improved child health. Then well organized child health services can further improve child health at the margins.

Let me illustrate briefly these fundamentally different approaches to child care in other countries. Every industrialized country in the world, except the U.S., has universally guaranteed paid parental leave after childbirth. Almost every industrialized country has a child allotment scheme--money, not coupons, to all families with children. In most European countries such financial benefits are not tied to means tests--every family gets it. In European countries quality education is in place for all children, free of charge, right through university and post-graduate levels. I hope these programs can be discussed at the conference because they are the most important factors in child health.

For those of us who work in child health, we have two responsibilities. First we must clean up our own act. In the case of the U.S., this must mean universal child health services. The

time for piecemeal, categorical approaches is over. Our second and equally important responsibility is to document to the public and its representatives the health consequences to children living in poverty and then to advocate forcefully for the fundamental changes necessary to reduce childhood poverty. I hope this conference will document how other countries improve child health through a broad package of programs to prevent or reduce childhood poverty and then come forward with a social policy and political agenda to start building such a broad package of programs in the U.S.--the most important step to improving child health.

*Smeeding T, Torrey B. "Poor Children in Rich Countries". Science, 1988. 242:873-877.

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